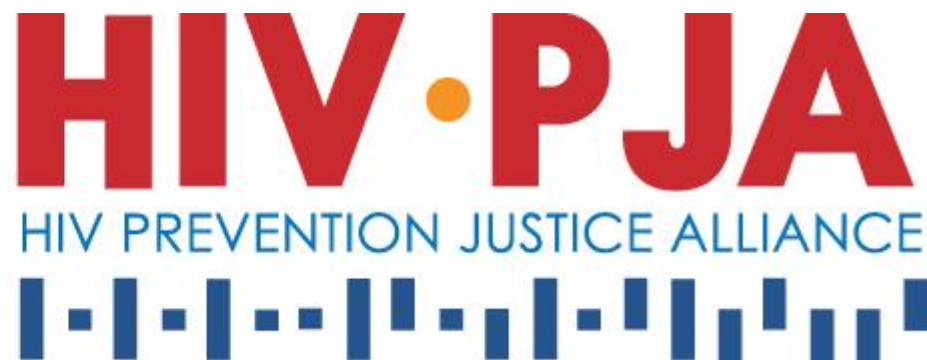




How to measure success: Improving our national HIV prevention indicators

Moderator: Jeremiah Johnson, Treatment Action Group

Keri N Althoff, Johns Hopkins Bloomberg School of Public Health

Denis Nash, PhD, MPH, City University of New York (CUNY)

Stefan Baral, Johns Hopkins Bloomberg School of Public Health

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Introductions and agenda

Jeremiah Johnson, HIV Prevention Research and
Policy Coordinator, *Treatment Action Group*



Today's Agenda

- **HIV incidence as a metric for HIV prevention in the United States**
 - **Denis Nash, PhD, MPH**, *City University of New York (CUNY)*; Executive Director, *CUNY Institute for Implementation Science in Population Health (ISPH)*; Professor of Epidemiology, *CUNY School of Public Health*
- **Measurement and Relevance for HIV Prevention and Treatment**
 - **Stefan Baral**, Associate Professor, *Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health*
- **Structural bridges and barriers to HIV prevention in the US**
 - **Keri N Althoff**, Associate Professor, *Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health*
- **Q&A**

HIV incidence as a metric for HIV prevention in the United States

Denis Nash, PhD, MPH

City University of New York (CUNY)

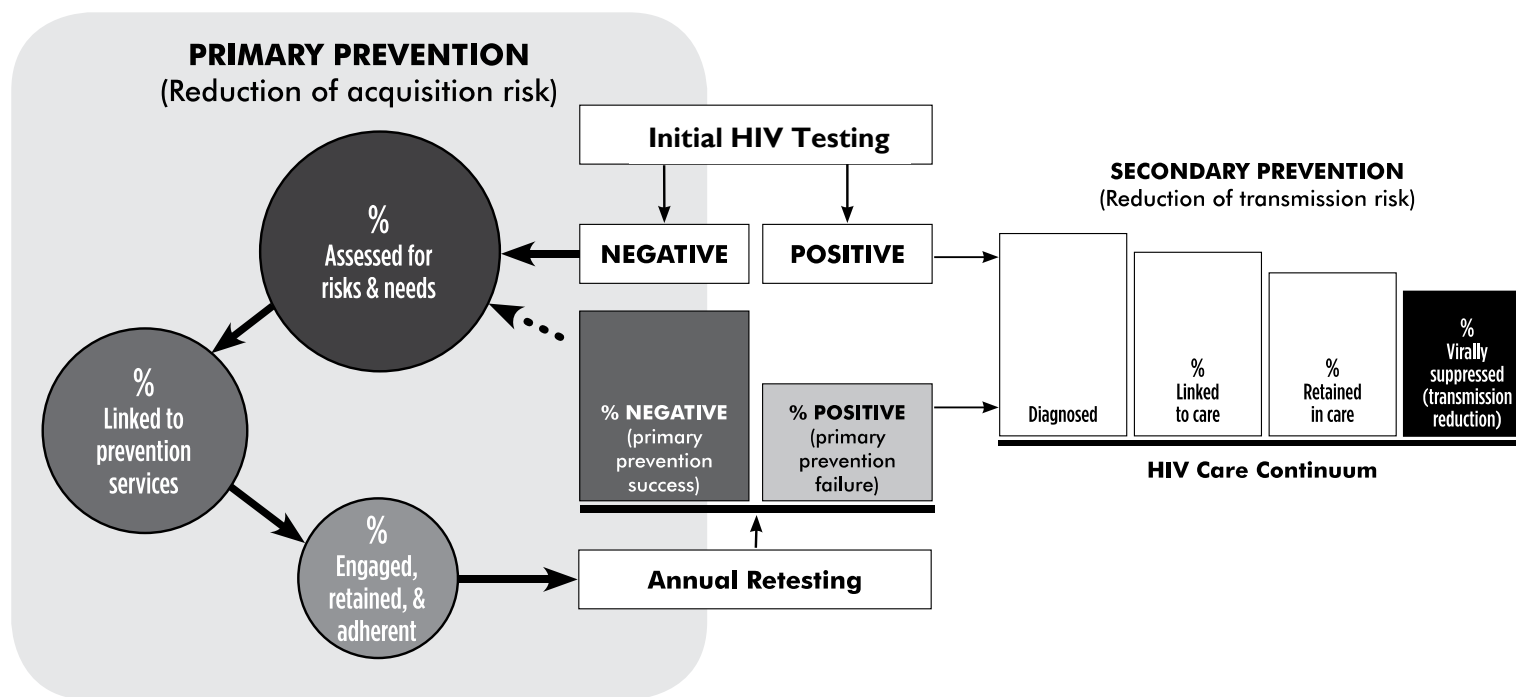
Executive Director, CUNY Institute for Implementation Science in Population Health (ISPH)

Professor of Epidemiology, CUNY School of Public Health

Outline

- ▶ The HIV Prevention and Care Continuum
- ▶ Importance of and Rationale for Incidence Estimation
- ▶ CDC Incidence Estimation Methods – Past approaches
- ▶ CDC Incidence Estimation Methods – Present/Future approaches
- ▶ Conclusions

An Integrated Primary and Secondary HIV Prevention Continuum: Conceptual Framework

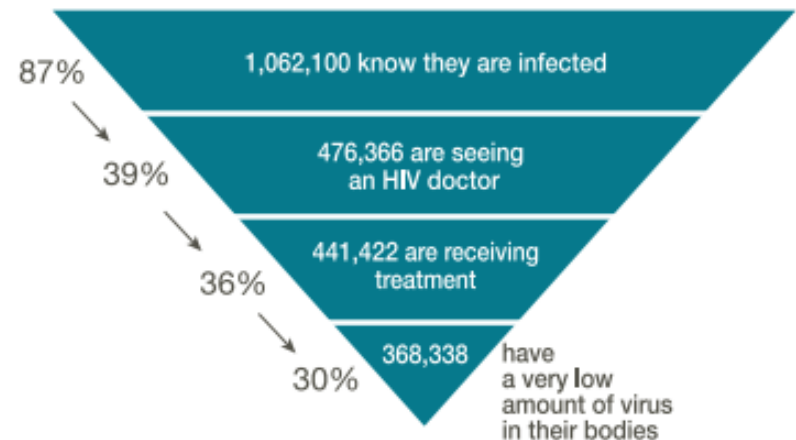


Source: Horn T, Sherwood J, Remien RH, Nash D, Auerbach JD, et al. Towards an integrated primary and secondary HIV prevention continuum for the United States: a cyclical process model. J Int AIDS Soc. 2016 Nov 17;19(1):21263. doi: 10.7448/IAS.19.1.21263.

Importance of and Rationale for Incidence Estimation

- ▶ **Monitor the HIV epidemic**
 - ▶ Who is becoming infected with HIV?
 - ▶ What are the trends in new infections?
 - ▶ What are the disparities in HIV incidence?
 - ▶ Helps interpret data on the number undiagnosed.
- ▶ **Monitor and evaluate success of prevention initiatives**
 - ▶ Avoiding new infections is the main point of the HIV prevention continuum and the first step on the HIV care continuum
- ▶ **Allocation of prevention resources**
 - ▶ Target resources according to burden and gaps

Percentage of HIV-Infected Individuals Engaged in Selected Stages of the Continuum of HIV Care, 2012



Source: <https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/todaysepidemic-508.pdf>

HIV Incidence versus HIV Diagnoses

- ▶ **HIV incidence** – number of HIV-negative people who become newly infected with HIV in a given year, regardless of whether they are diagnosed with HIV in that year.
- ▶ **HIV diagnoses** – number of HIV+ people who receive an HIV diagnosis in a given year, regardless of whether they became infected in that same year or a prior year.
- ▶ New HIV diagnoses in a given year do not necessarily reflect new HIV infections in that same year because many people diagnosed with HIV in a given year were infected years ago.
 - ▶ E.g., among those initially diagnosed with HIV infection during 2014, **one-quarter (23%)** were simultaneously **diagnosed with AIDS** (i.e., likely infected several years prior to dx)
 - ▶ New HIV diagnoses would only be essentially equivalent to new HIV infections if everyone infected with HIV was diagnosed right around the same time that they were infected

CDC Incidence Estimation Methods – Past approaches

- ▶ Extended Back-Calculation approaches used historically (through 2006)
 - ▶ Reconstruction of the HIV incidence curve from AIDS incidence data and the date of the first positive HIV test
 - ▶ Date of infection is estimated (back-calculated) based on timing of AIDS diagnosis

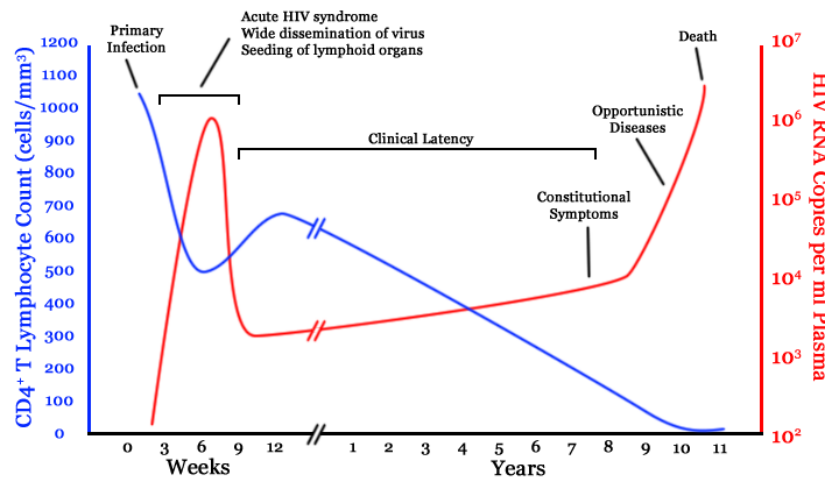


Figure adapted from Pantaleo et al.
NEJM 1993

- ▶ In the US, us
2006 was 55,400 (95% CI 50,000 – 60,800)

new HIV infections in

Hall, et al., 2008 Estimation of HIV Incidence in the United States. JAMA vol 300 (5).

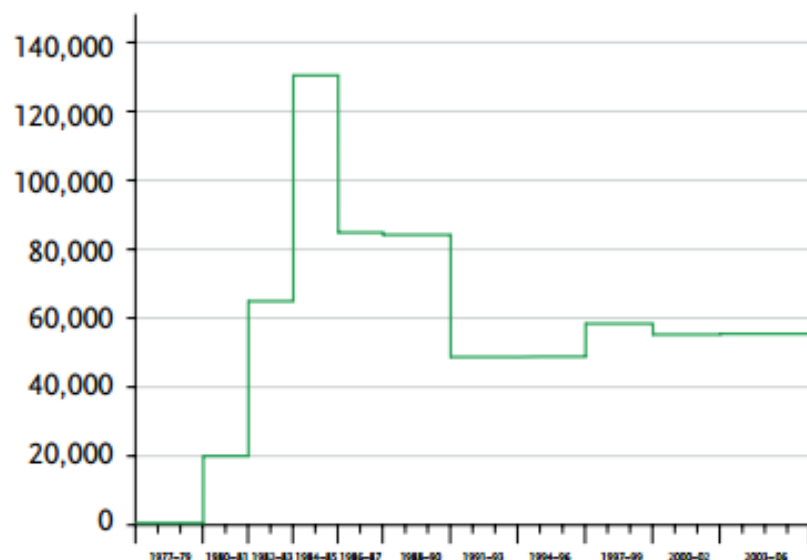
Biomarker approaches used as of 2006 CDC Incidence Estimation Methods – Past approaches

- ▶ CDC implemented population-based HIV incidence surveillance
- ▶ Known as serologic testing algorithm for recent HIV seroconversion (STARHS)
- ▶ Relies on a BED assay to indicate if a newly diagnosed person was recently infected with HIV (i.e., in the 6 months prior to their diagnosis)
- ▶ In the US, using this method, the **estimated number of new HIV infections in 2006** was **56,300 (95% CI: 48,200-64,500)**.

Hall, et al., 2008 Estimation of HIV Incidence in the United States. JAMA vol 300 (5).

Extended Back-Calculation vs. Biomarker Approach

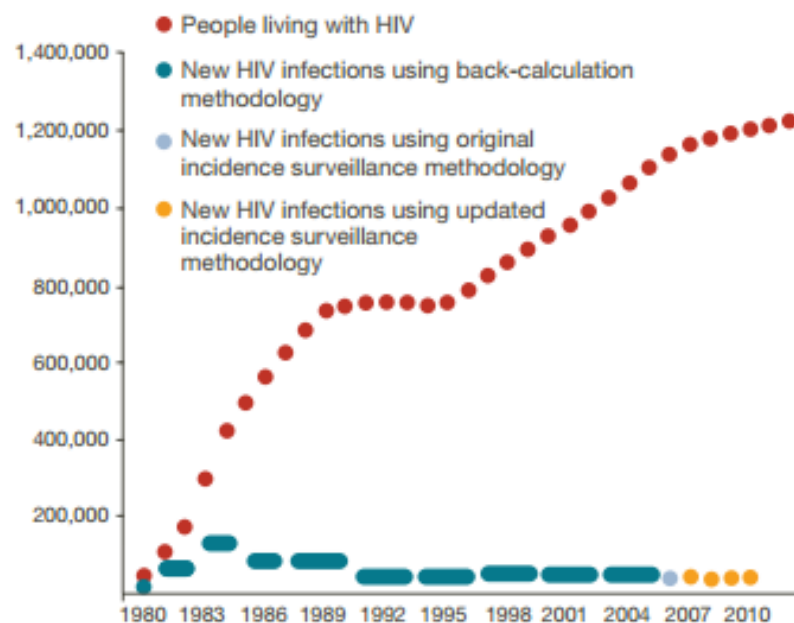
Figure 1. Estimated New HIV Infections, Extended Back-Calculation Model, 1977–2006, Overall



Note: Estimates are for 2-year intervals during 1980–1987, 3-year intervals during 1977–1979 and 1988–2002, and a 4-year interval for 2003–2006.

(CDC, <https://www.cdc.gov/nchhstp/newsroom/docs/fact-sheet-on-hiv-estimates.pdf>)

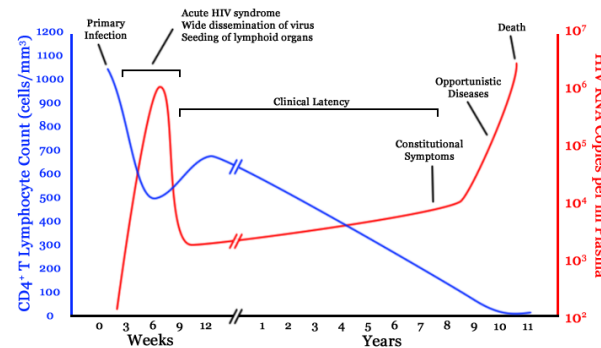
HIV Prevalence and New Infections, 1980–2012



(CDC, <https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/todays-epidemic-508.pdf>)

CDC Incidence Estimation Methods – Present/Future approach

- ▶ Using the first CD4 reported at diagnosis
 - ▶ Estimate the delay from infection to diagnosis based on well-characterized CD4 depletion parameters (i.e., rate of CD4 decline in those with untreated HIV infection)

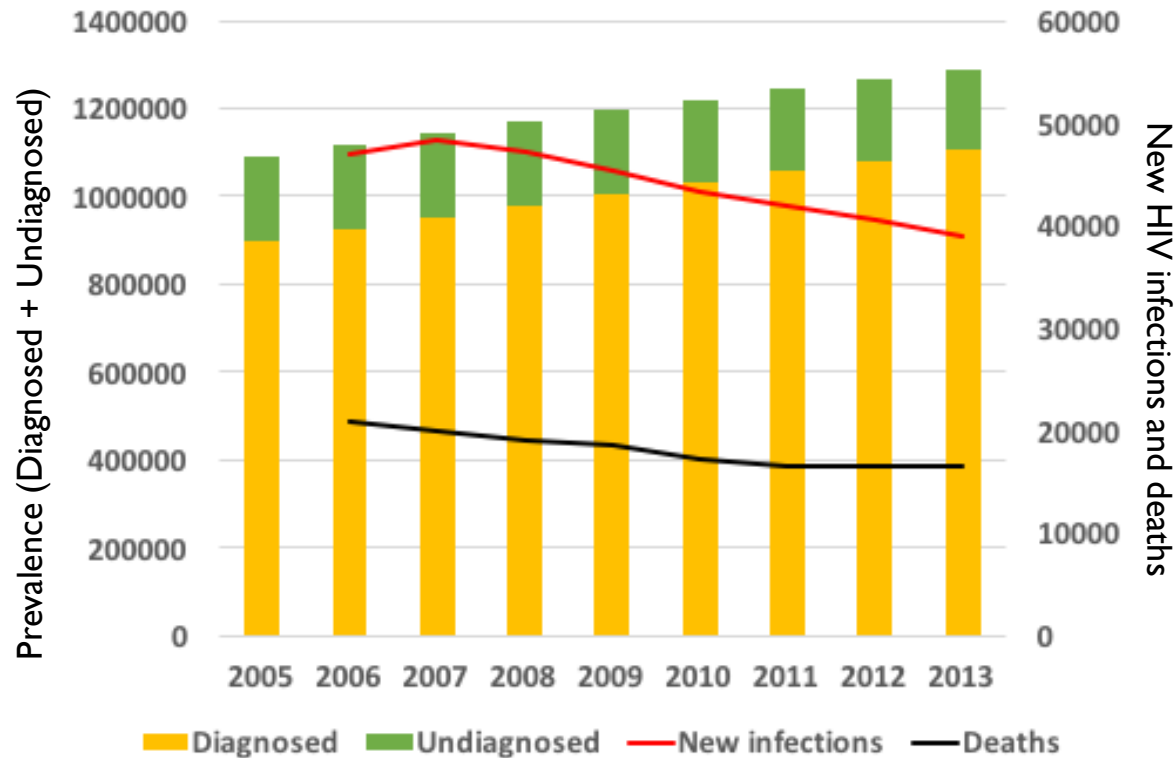


Adapted from
Pantaleo et al. NEJM
1993

- ▶ The distribution (time from infection to diagnosis) is then used to estimate the timing of new infections relative to diagnosis based on the first CD4 value
- ▶ In the US. Using this method, the annual number of **new infections decreased**
 - ▶ From 48,300 (95% CI 47,300-49,400) in 2007
 - ▶ To **39,000 (95% CI 36,600, 41,400) in 2013**

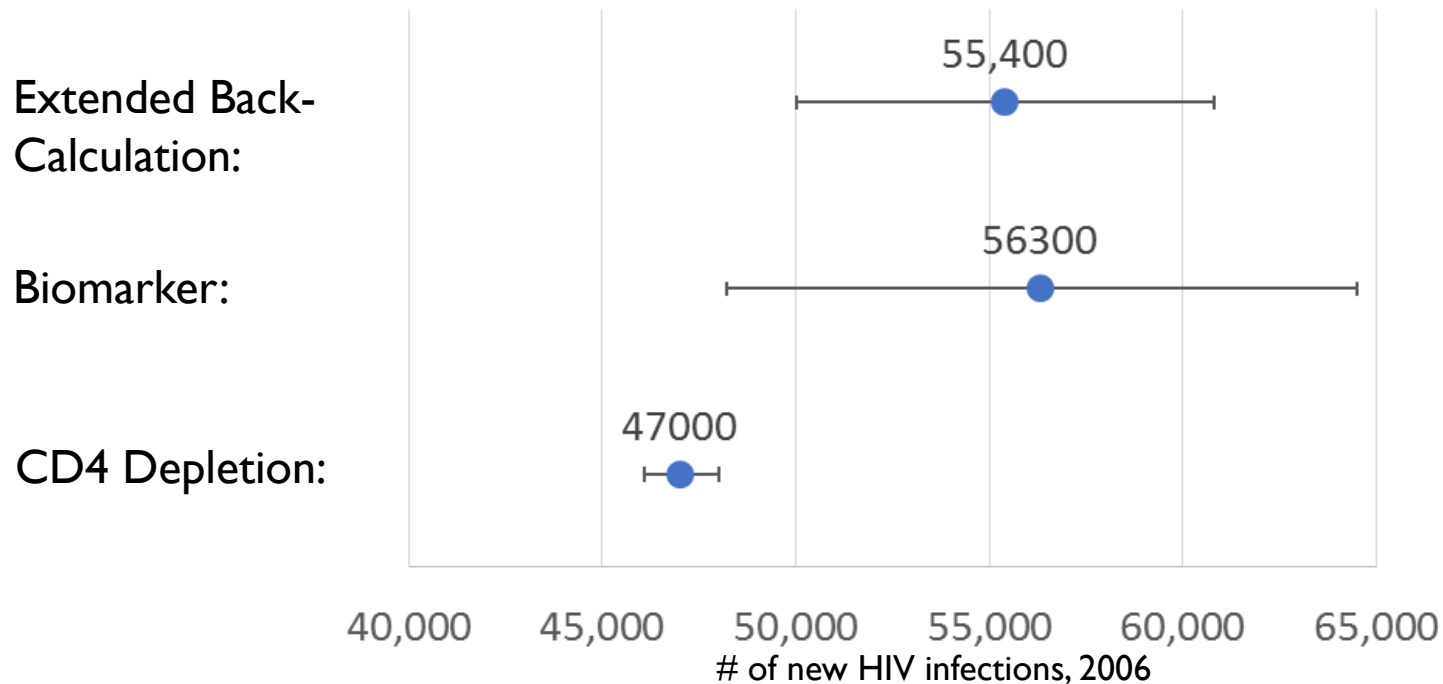
Song et al. 2016. Using CD4 Data to Estimate HIV Incidence, Prevalence, and Percent of Undiagnosed Infections in the United States. *JAIDS*

Estimates of HIV incidence, prevalence, and deaths among PLWH from Models based on CD4 Depletion



Adapted from Song et al. 2016. Using CD4 Data to Estimate HIV Incidence, Prevalence, and Percent of Undiagnosed Infections in the United States. *JAIDS*

Comparison of 2006 HIV Incidence Estimates by Different Approaches



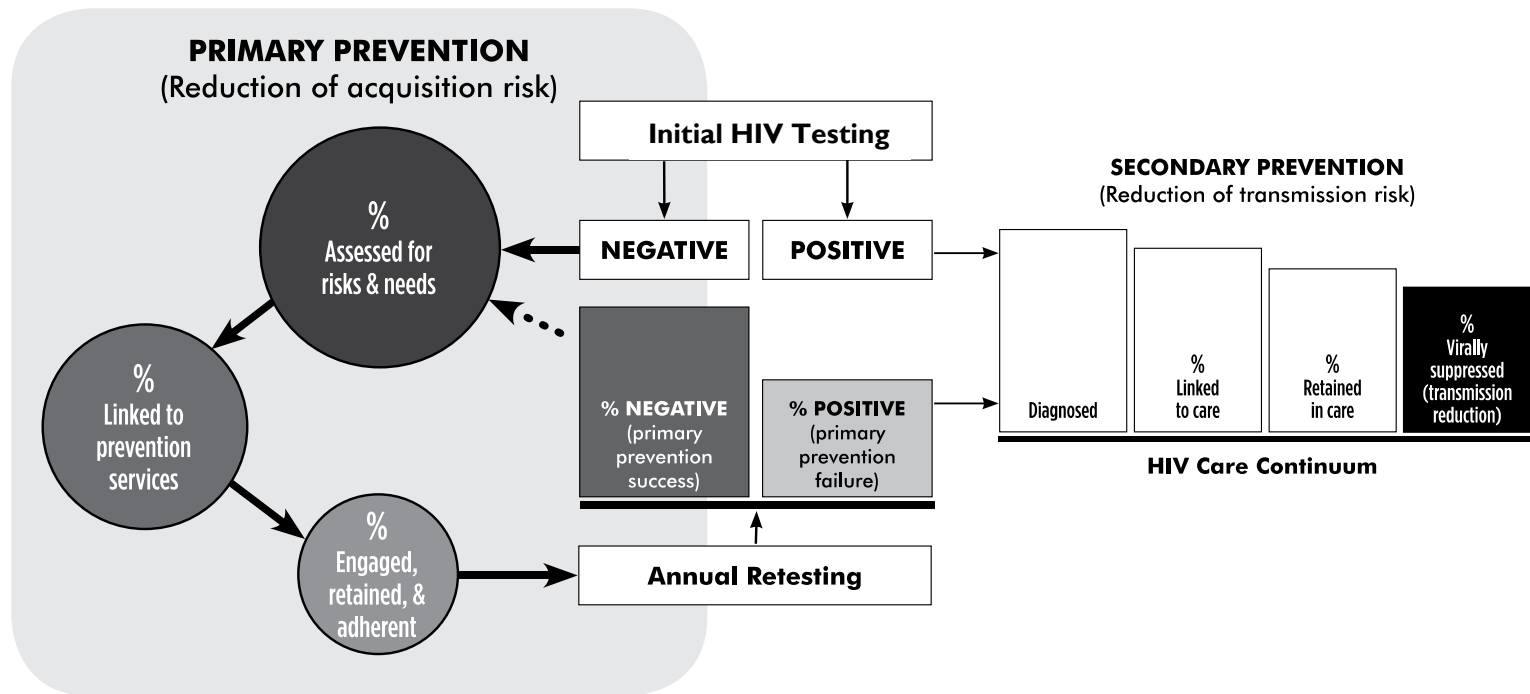
New national HIV incidence estimates are significantly lower for 2006, but may be more precise (i.e., tighter confidence intervals)

Hall, et al., 2008 JAMA and Song et al., 2016 JAIDS

How Might Incidence Estimation be Falling Short

- ▶ They take a long time to produce, especially at the national level (lag)
- ▶ Incidence estimates don't characterize timing of key events (e.g., time from infection to viral suppression)
- ▶ Incidence estimates don't capture information on acute infection (i.e., percent of new diagnoses that are acute infection)
 - ▶ Many jurisdictions don't collect this information
- ▶ Incidence estimates don't really drive prevention at the local level.
 - ▶ At a population level, we rarely tie new infections to prevention policies (e.g., targeted testing or expanded guidelines or PrEP delivery)
 - ▶ Who are the missed opportunities for HIV prevention in the era of PrEP? Where are the PrEP implementation gaps?

An Integrated Primary and Secondary HIV Prevention Continuum: Conceptual Framework



Horn T, Sherwood J, Remien RH, Nash D, Auerbach JD, et al. Towards an integrated primary and secondary HIV prevention continuum for the United States: a cyclical process model. J Int AIDS Soc. 2016 Nov 17;19(1):21263. doi: 10.7448/IAS.19.1.21263.

Acknowledgements

- ▶ McKaylee Robertson, MPH – Institute for Implementation Science in Population Health (ISPH), City University of New York
- ▶ Jeremiah Johnson – Treatment Action Group
- ▶ Tim Horn – Treatment Action Group





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Stigma

Measurement and Relevance for HIV Prevention and Treatment

Stefan Baral, MD MPH

Key Populations Program

Center for Public Health and Human Rights, JHSPH



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Outline

- Measuring Stigma
- Developing Stigma Metrics
 - Methods
 - Systematic Review
- Prevalence of Stigma across Regions
- Stigma Pathways of Action
- Moving Forward



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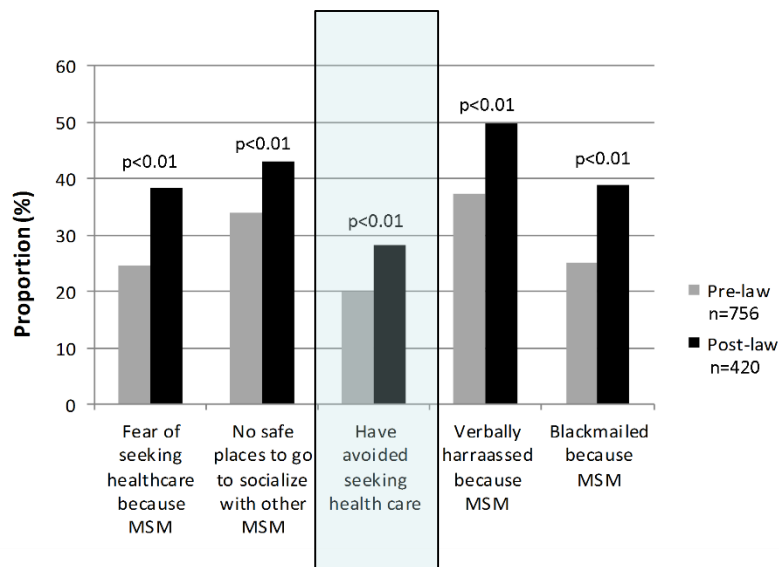
Why Measure Stigma?

- Stigma, Rights Violations, and HIV Risks are intricately linked
 - Limits Coverage of HIV Prevention and Treatment Programs
 - Challenges Provision of Services
 - Challenges Uptake of Services
 - Data Paradox
 - Least data in the most stigmatizing settings

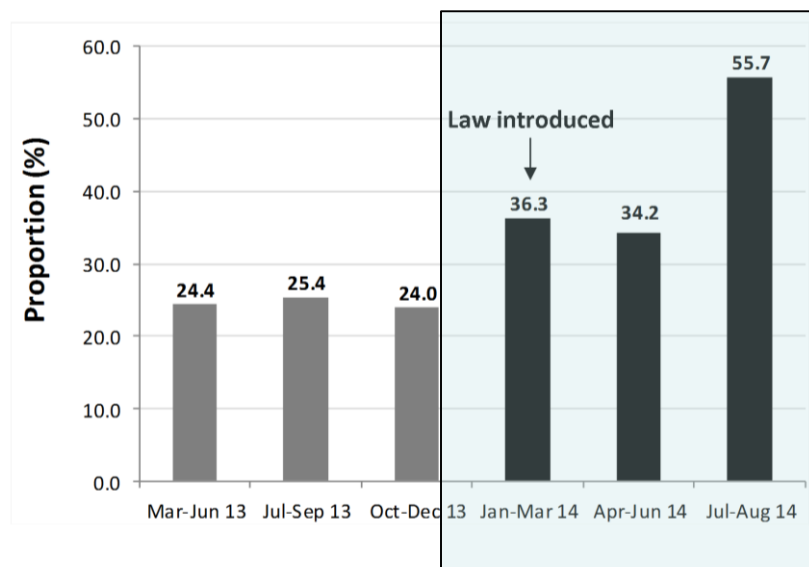


Legislation and HIV Risks among MSM in Nigeria

- Reporting of Discrimination and Stigma During Study Visits Pre and Post Legislation



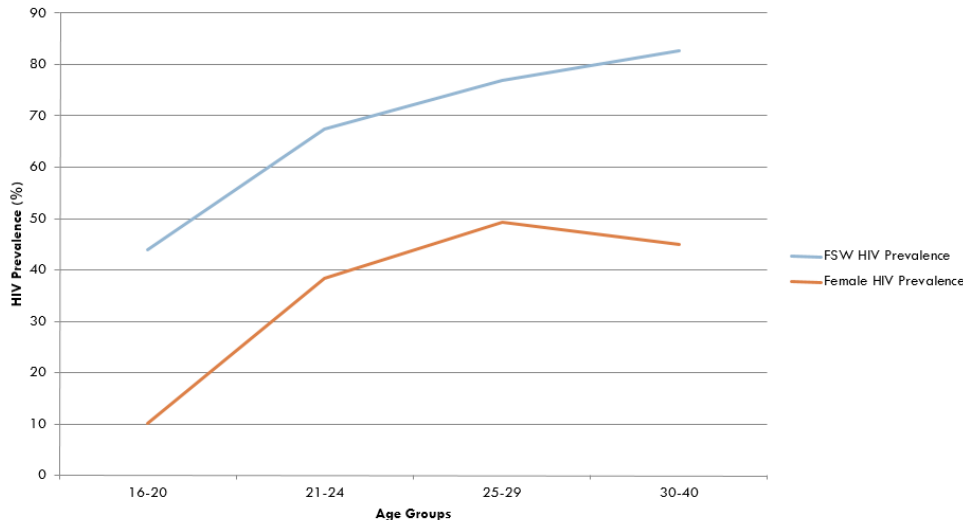
- Cumulative lifetime experiences of reported fear of seeking health care services across study visits (n=1,175 visits).



- HIV Prevalence ~45%, HIV Incidence ~14%

Disclosure of Sex Work Status in Swaziland

- Disclosure of Sex Work to
 - Family Member
 - 30.3% (98/325)
 - Health Care Worker
 - 25.9% (84/325)



Afraid to Seek Health Care

- aOR 3.5 (95% CI 1.3-5.6)
disclosed sex work to HCW
- aOR 2.0 (95% CI 1.12-3.7)
being treated for HIV



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Stigma and Suicidal Ideation among MSM in West Africa

	<u>OR</u>	<u>95% CI</u>	<u>aOR^a</u>	<u>95% CI</u>
Family exclusion	2.28***	1.52, 3.42	2.22***	1.43, 3.43
Family gossip	2.68***	1.99, 3.64	2.50***	1.79, 3.50
Friend rejection	2.38***	1.73, 3.26	2.17***	1.53, 3.07
Treated poorly in healthcare setting	2.51**	1.41, 4.45	1.99*	1.07, 3.71
Healthcare worker gossiped	1.54	0.91, 2.59	1.41	0.81, 2.43
Physically hurt	3.83***	2.57, 5.72	2.94**	1.91, 4.52
Tortured	3.84***	2.24, 6.60	3.86***	2.17, 6.86
Raped	3.36***	2.30, 4.89	3.07***	2.05, 4.60
Social cohesion	0.97**	0.94, 0.99	0.98	0.95, 1.00
Social participation	0.92*	0.86, 0.98	0.91*	0.85, 0.99
*p<0.05; **p<0.01; ***p<0.001				

^aAdjusts for age, gender identity, study site, marital status, self-reported HIV status, and disclosure of sexual identity to family members or healthcare workers



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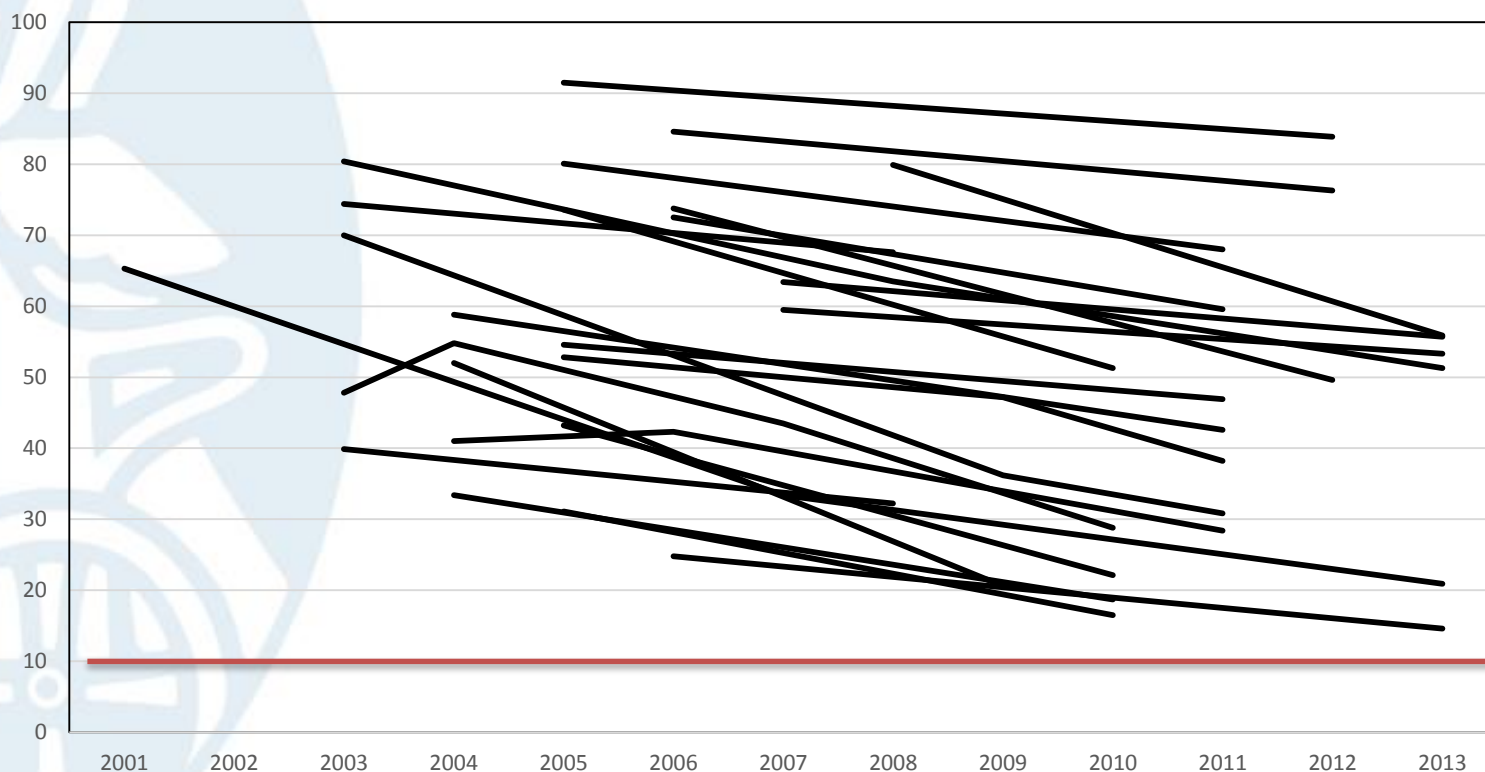
Evidence Supporting Relevance of Stigma for HIV

- **HIV infection associated with**
 - Experienced Stigma among MSM
 - Sweitzer 2014, MSM Togo; Baral et al 2011, MSM peri-urban Cape Town
 - Perceived Stigma among FSW
 - Peitzmeier et al 2013, FSW Gambia
- **Diagnosed/treated for STI associated with**
 - Fear of seeking healthcare because MSM
 - Fay et al 2010; MSM Malawi, Namibia, Botswana
 - Denied healthcare because MSM
 - Fay et al 2010; MSM Malawi, Namibia, Botswana



Normalising HIV?

% “No” responses to the question “Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?” among women from 62 nationally-representative surveys in 24 countries (2001-2013)



Slow decline:
On average across all countries 90% “Yes” expected by 2024

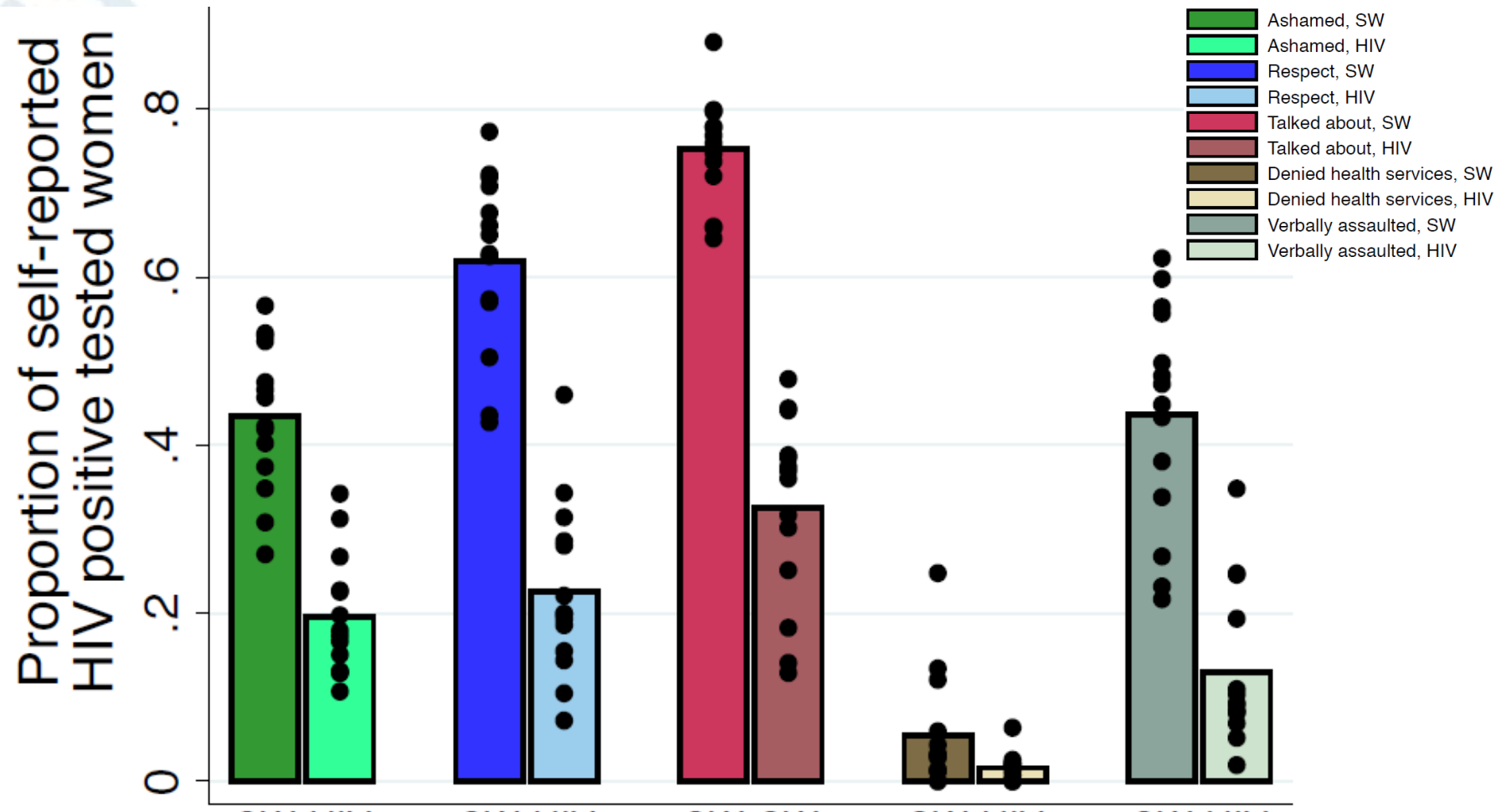
Countries included: Benin, Cameroon, Congo, Cote d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Zambia, Zimbabwe

Source: Hargreaves, et al. 2015

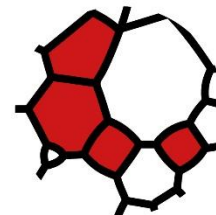
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MEDICINE



Stigma Among 1118 Female Sex Workers Living with HIV from 14 sites Across Zimbabwe, 2012 (SAPPH-Ire Trial data)

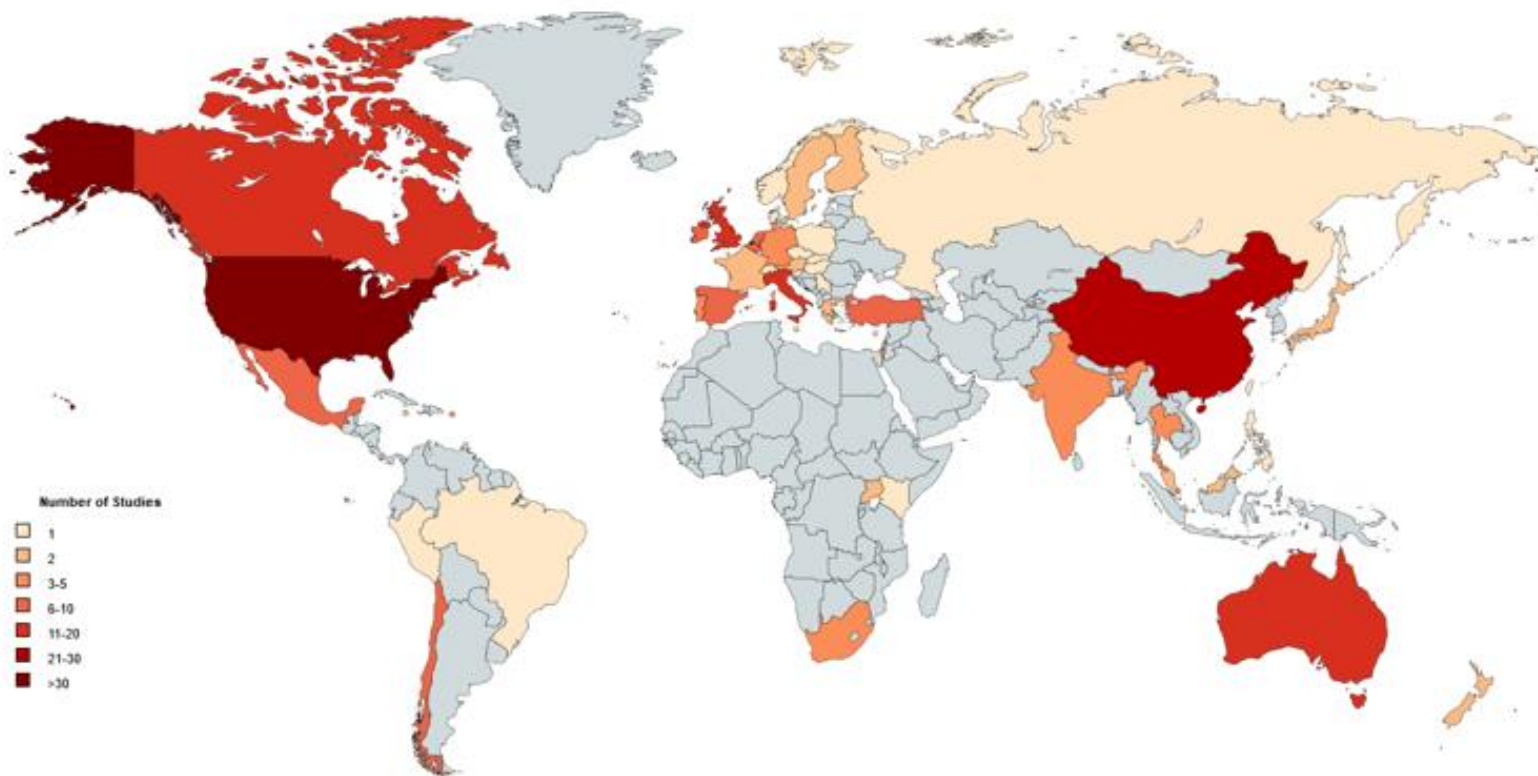


Source: Hargreaves, Cowan, et al. 2015



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Where Stigma Data Are Available for Key Populations



Geographic distribution of studies by country

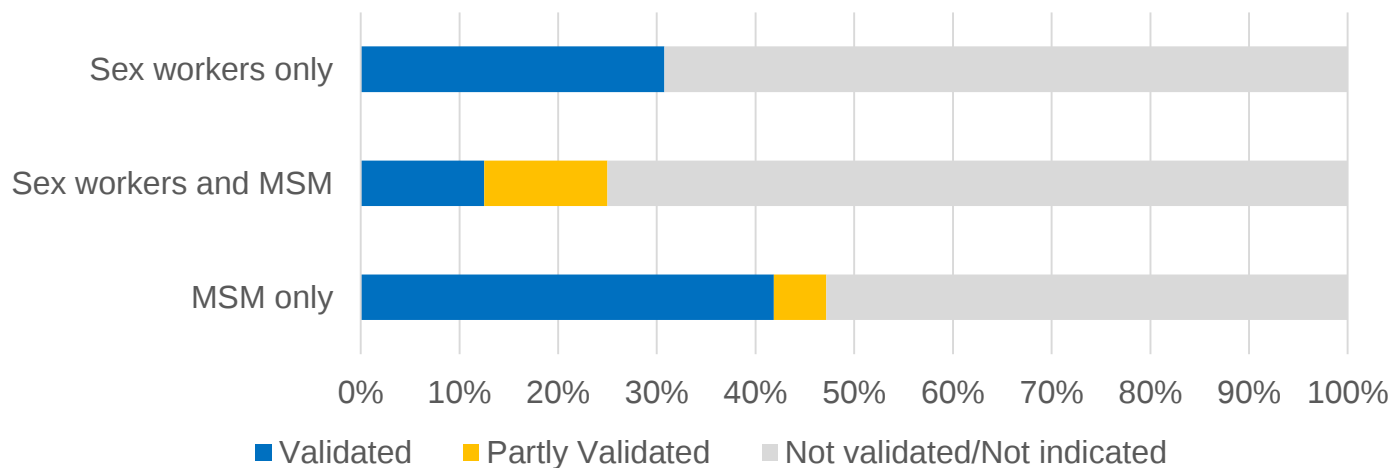


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Validated Stigma Metrics Used

	MSM only	SW and MSM	SW only	PWID	Total
Validated	221	1	4	0	226
Partly Validated	28	1	0	0	29
Not validated	279	6	9	0	294
Total	528	8	13	0	549





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Factor Analyses for Stigma Metrics among Key Populations

- **Data**
 - 4,315 MSM, 4,800 FSW aged 18 years and older
 - Burkina Faso, Cote d'Ivoire, Lesotho, Nigeria, Senegal, Swaziland, and Togo
 - Data collected from 2013-2015, primarily via RDS
- **Analytic approaches**
 - Exploratory factor analysis by region
 - Rotated factors using Promax oblique rotation
 - Factors retained based on
 - Eigenvalues
 - Scree plots





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– MSM Stigma Scale

- 4 factors

1. Enacted Community Stigma
2. Stigma from Family and Friends
3. Perceived Healthcare Stigma
4. Enacted Healthcare Stigma

– FSW Stigma Scale

- 5 factors

1. Enacted Community Stigma
2. Stigma from Family and Friends
3. Perceived Healthcare Stigma
4. Enacted Healthcare Stigma
5. Stigma from Uniformed Officers

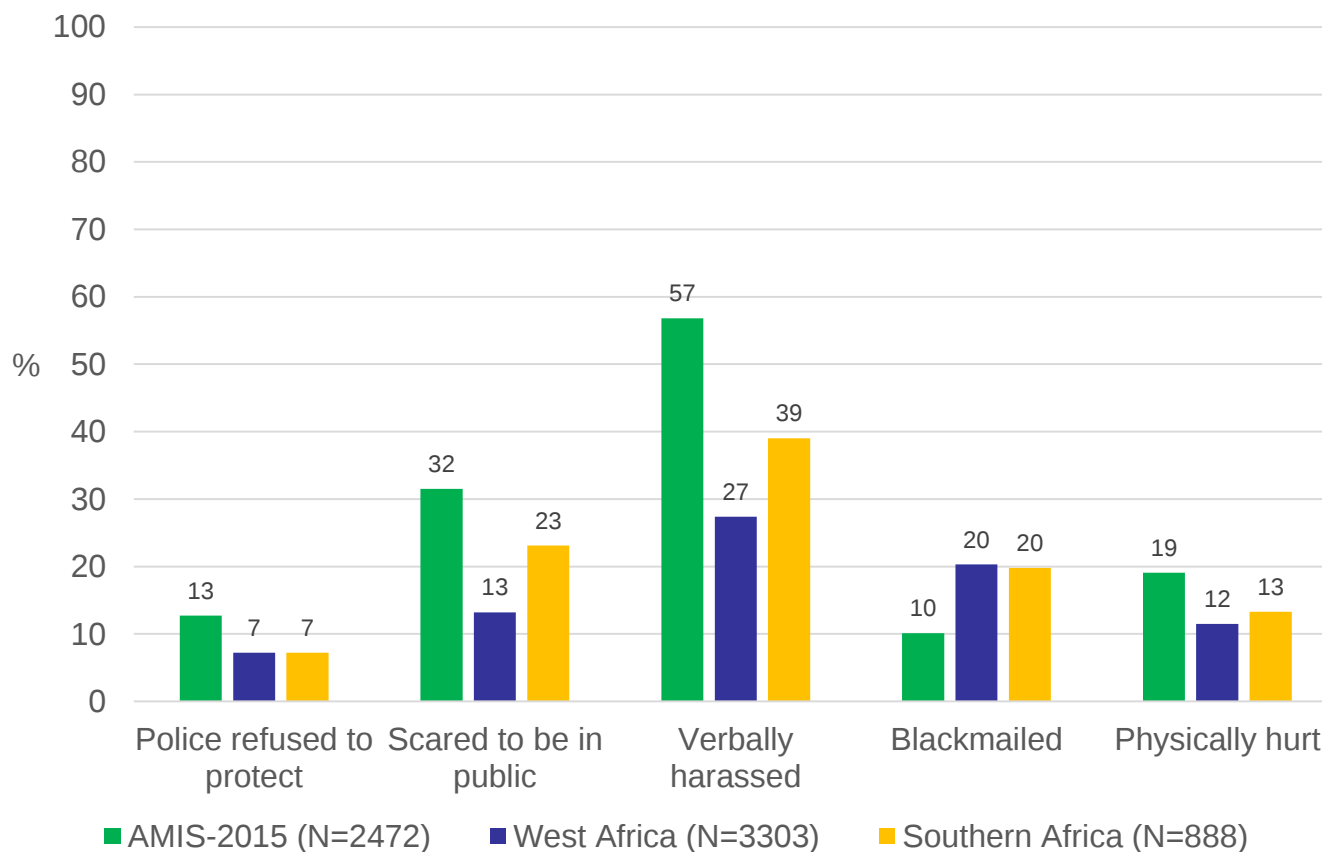




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Prevalence of Community Level Stigma Affecting Men who have Sex with Men across the US and Sub-Saharan Africa



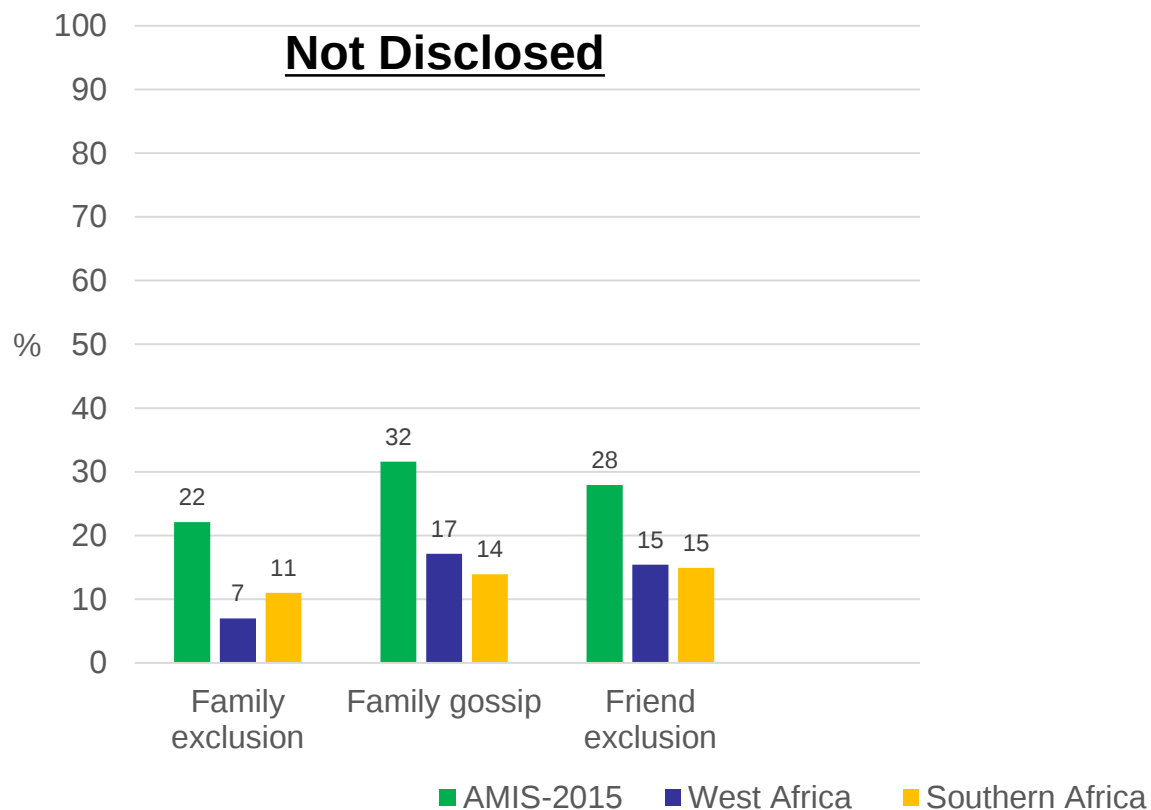
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Source: Sanchez T, RC Sineath, EM Kahle, SJ Tregear, and PS Sullivan. The Annual American Men's Internet Survey of Behaviors and Men Who Have Sex with Men in the US. 2015.



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Prevalence of Sexual Behavior Stigma from Family/Friends among MSM Who Disclosed vs. Not Disclosed to Family

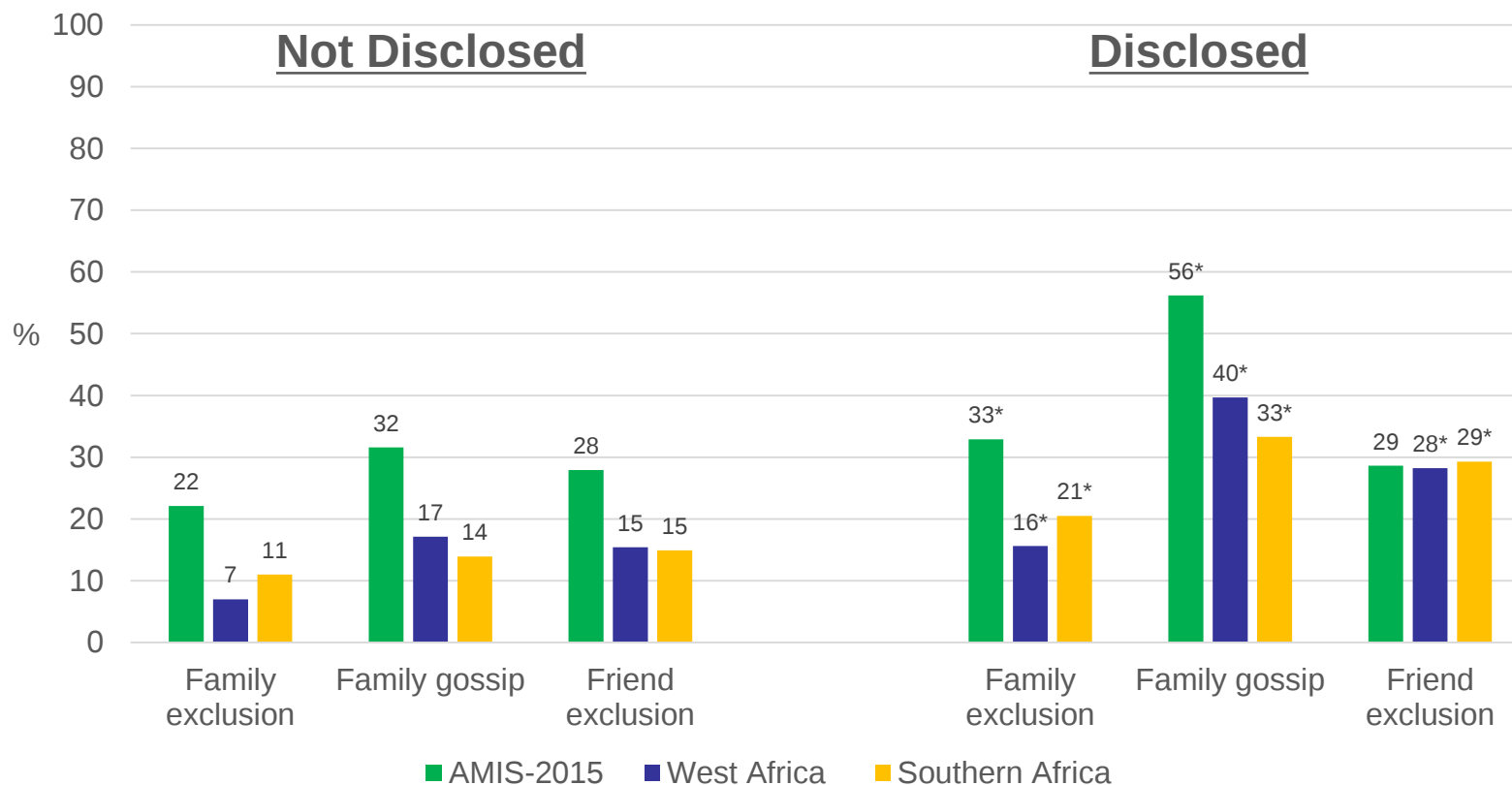




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Prevalence of Sexual Behavior Stigma from Family/Friends among MSM Who Disclosed vs. Not Disclosed to Family



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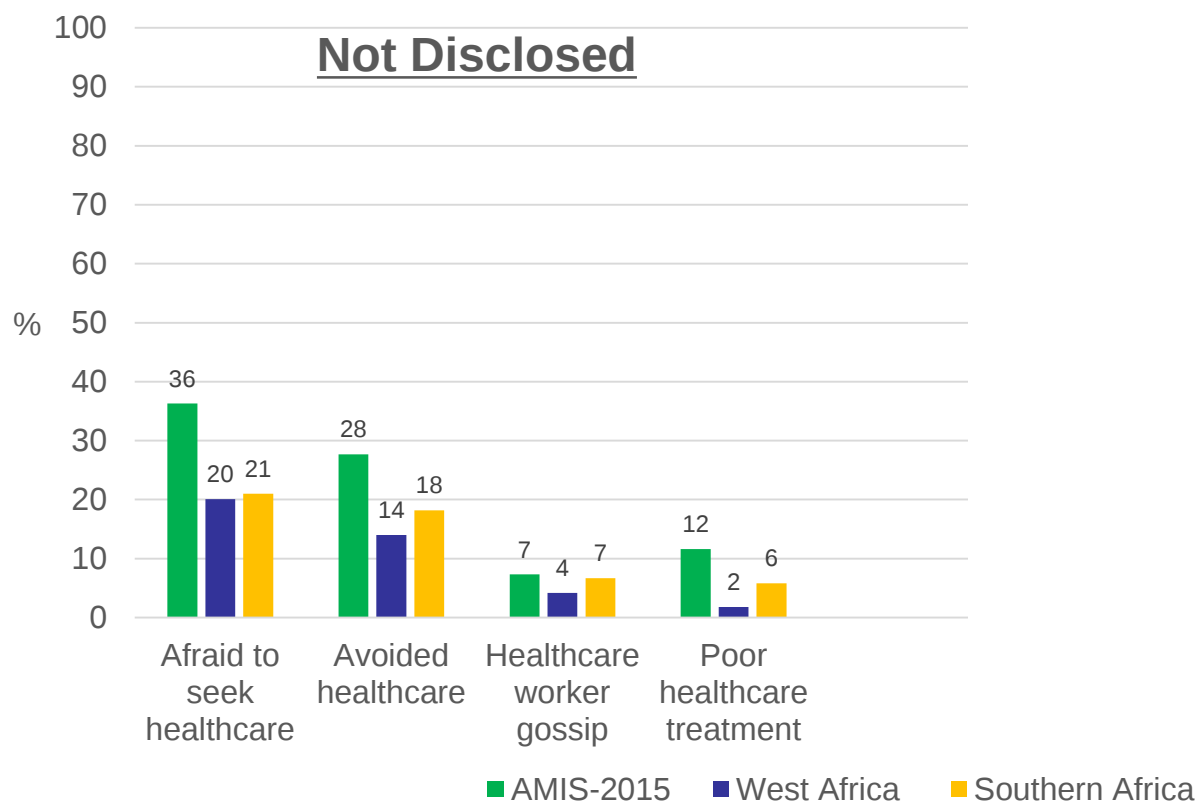
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*p<0.01

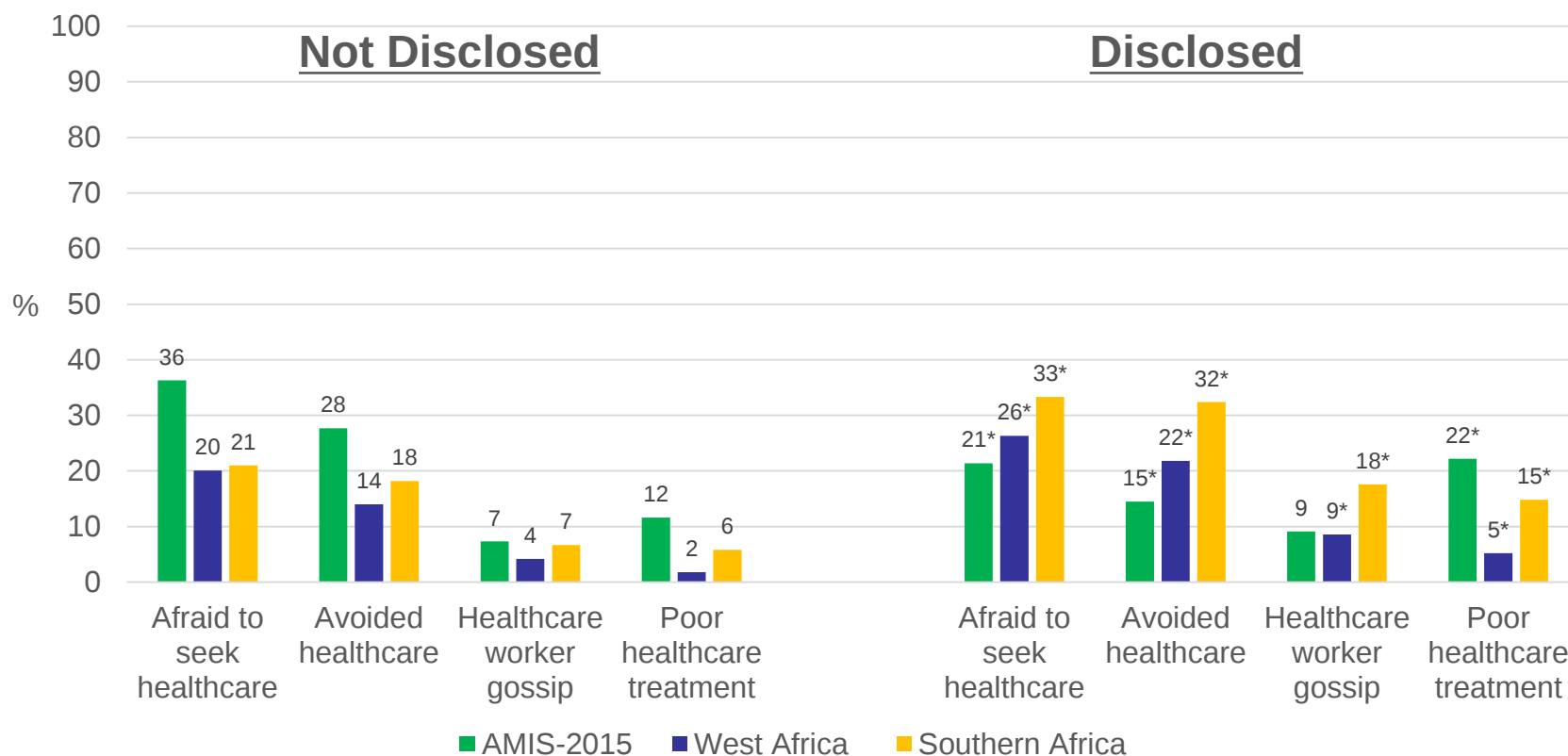


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Prevalence of Sexual Behavior Stigma from Healthcare Settings among MSM Who Disclosed vs. Not Disclosed Sexual Behaviors to Healthcare Workers



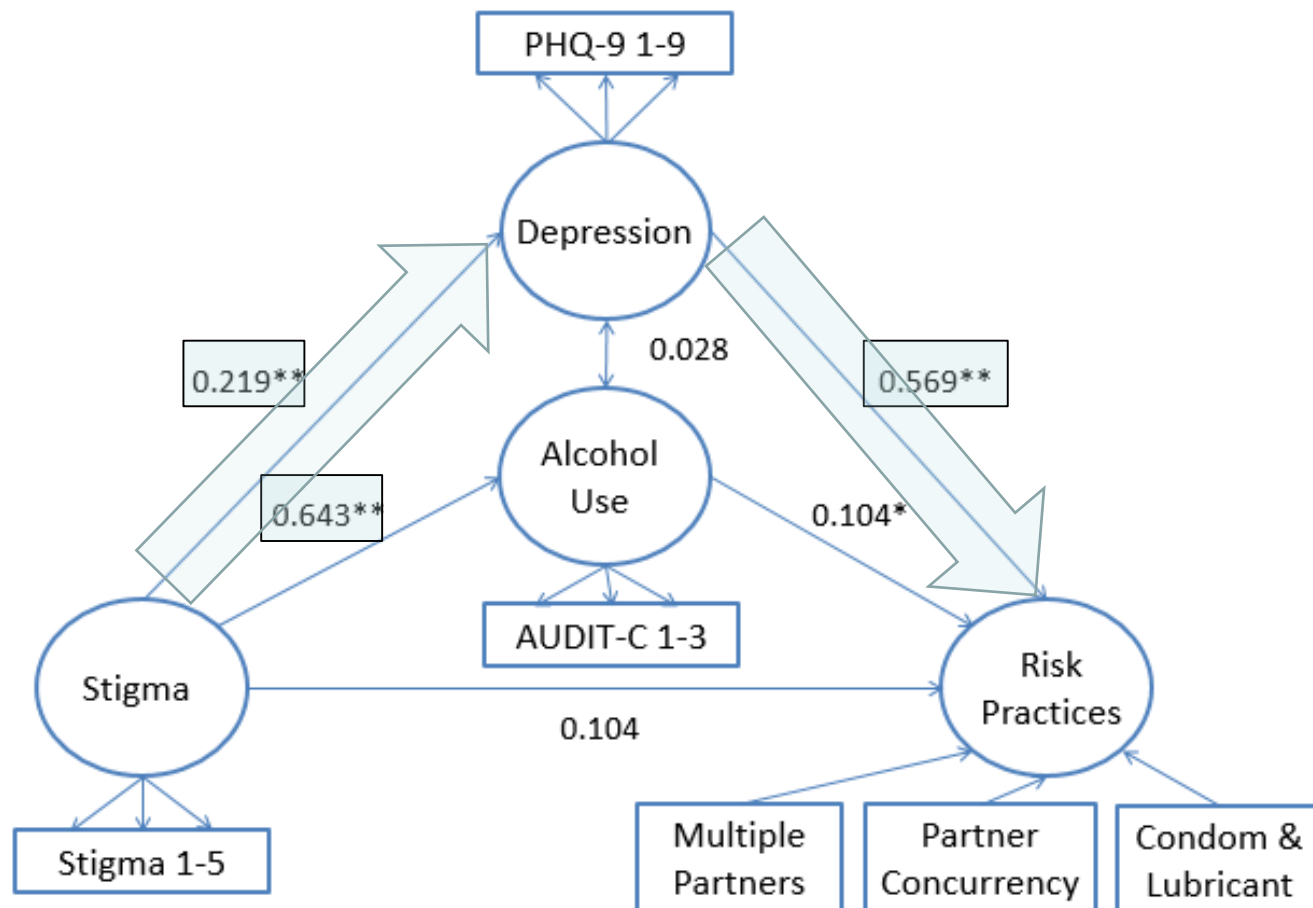
Prevalence of Sexual Behavior Stigma from Healthcare Settings among MSM Who Disclosed vs. Not Disclosed Sexual Behaviors to Healthcare Workers



Potential Causal Pathway for Stigma and HIV-Risks

Structural Equation Model

- Indirect effect of stigma in health system on sexual risk practices
- 527 MSM from Lesotho
- * $p=0.072$; ** $p<0.01$





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Strategies for the Measurement of Stigma

Population	Data collection platforms	What can be asked
Key populations (regardless of HIV status)	Surveys or cohorts using specialised sampling methodology such as RDS, TLS, or internet	Experienced, Perpetrated, Perceived, Anticipated, and Internalised stigma
	Targeted service delivery platforms contacts	
PLHIV (who may be key populations)	Representative surveys of PLHIV - Collect data on stigmatised practices - Surveys or cohorts using specialised sampling methodology such as RDS, TLS, or internet	Experienced, perpetrated, perceived, anticipated, and internalised stigma as a result of specific attributes or behaviours and/or HIV status
	HIV treatment and care programmes that are also able to collect data on stigmatised practices	
Non-key populations (regardless of HIV status)	Population surveys or cohorts	Stigmatising attitudes towards practices and HIV status
Health workers	Health worker surveys or cohorts	Perceptions / observations of stigma or discrimination
		Report of own discriminatory behaviours
RDS-Respondent-driven sampling, TLS-Time-location sampling		



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Moving Forward

Despite rhetoric, stigma is an understudied social determinant of health in HIV epidemiologic and prevention studies

Stigma is quantitatively measurable and represents an actionable risk factor for the HIV acquisition and transmission

There appear to be more similarities than differences in the prevalence of stigma among key populations around the world

Increasingly systematizing the study of stigma will advance the field and likely increase uptake of stigma indicators



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Acknowledgements

- **Key Populations Program**
 - Carrie Lyons, Amrita Rao, Shauna Stahlman, Sosthenes Ketende, Ben Liestman, Sheree Schwartz, Gnilane Turpin Nunez, Karleen Coly, Iliassou Mfochive Njindam, Clarence Yah
- **Enda Santé**
 - Daouda Diouf, Fatou Drame, Ibrahima Ba, Nguissali Turpin, Nuha Ceesay, Rebecca Ezouatchi
- **MeSH Consortium**
 - James Hargreaves, Brian Rice, Kathie Granger
- **Collaborators**
 - PAMAC, EVT, IRSS, AIDSETI, Matrix, HSRC
- **USAID Headquarters and West And Central Africa**
 - Alison Cheng, Delivette Castor, Cameron Wolf, Tisha Wheeler, Laurent Kapesa
- **Emory/AMIS**
 - Travis Sanchez, Patrick Sullivan
- **CPHHR**
 - Chris Beyrer, Emily Clouse, Andrea Wirtz, Kristin Hunt, Michele Decker, Len Rubinstein



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Structural bridges and barriers to HIV prevention in the US

Keri Althoff, PhD, MPH

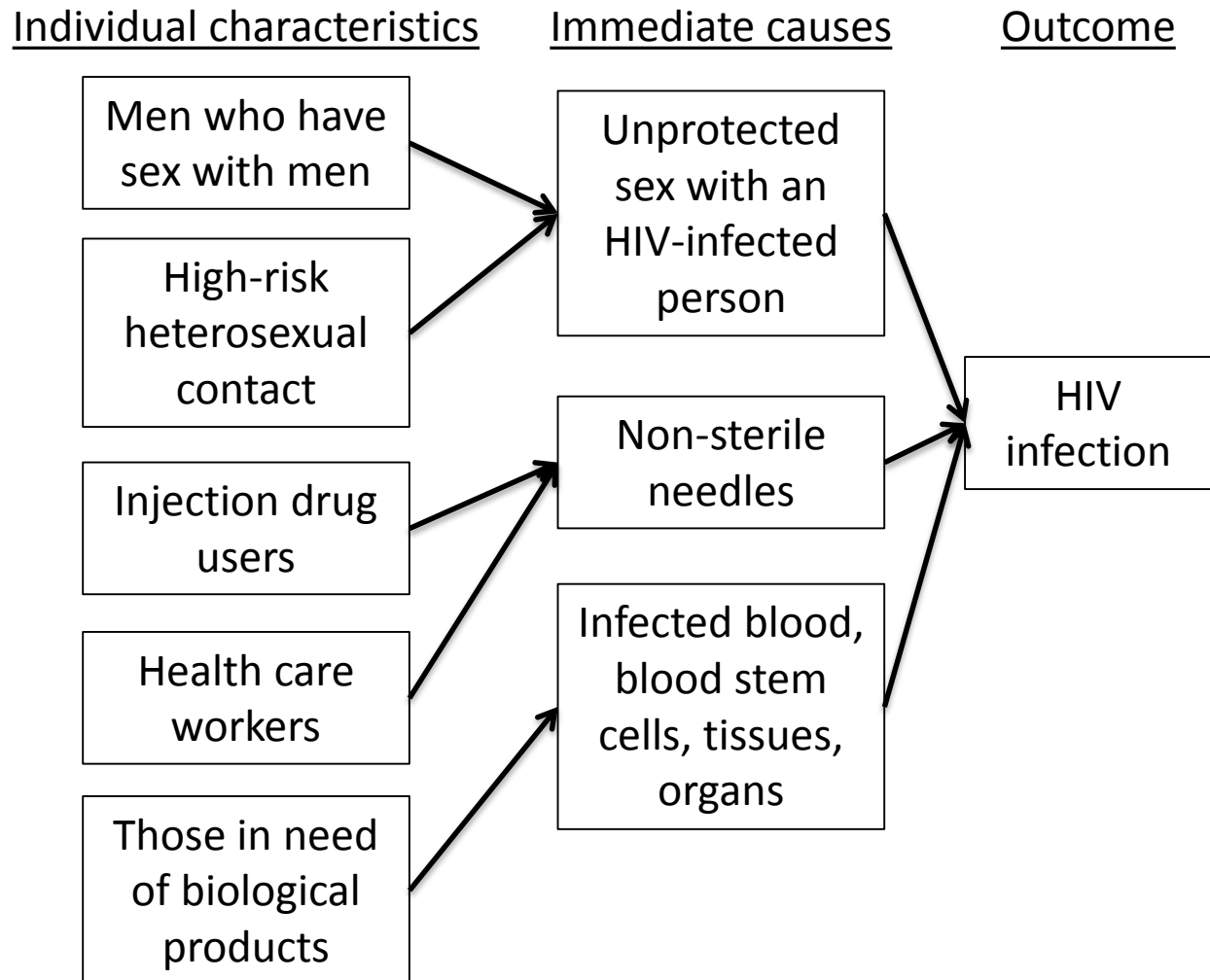
Associate Professor

Johns Hopkins Bloomberg School of Public Health

Overview

- Existing structural bridges and barriers
- New initiatives

Barriers to prevention



Barriers to prevention

Individual characteristics

Men who have
sex with men

High-risk
heterosexual
contact

Injection drug
users

Health care
workers

Those in need
of biological
products

Immediate causes

Unprotected
sex with an
HIV-infected
person

Non-sterile
needles

Infected blood,
blood stem
cells, tissues,
organs

Outcome

HIV
infection



Barriers to prevention

Individual characteristics

Men who have
sex with men

High-risk
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contact

Injection drug
users

Health care
workers

Those in need
of biological
products

Screening (1985)

Immediate causes

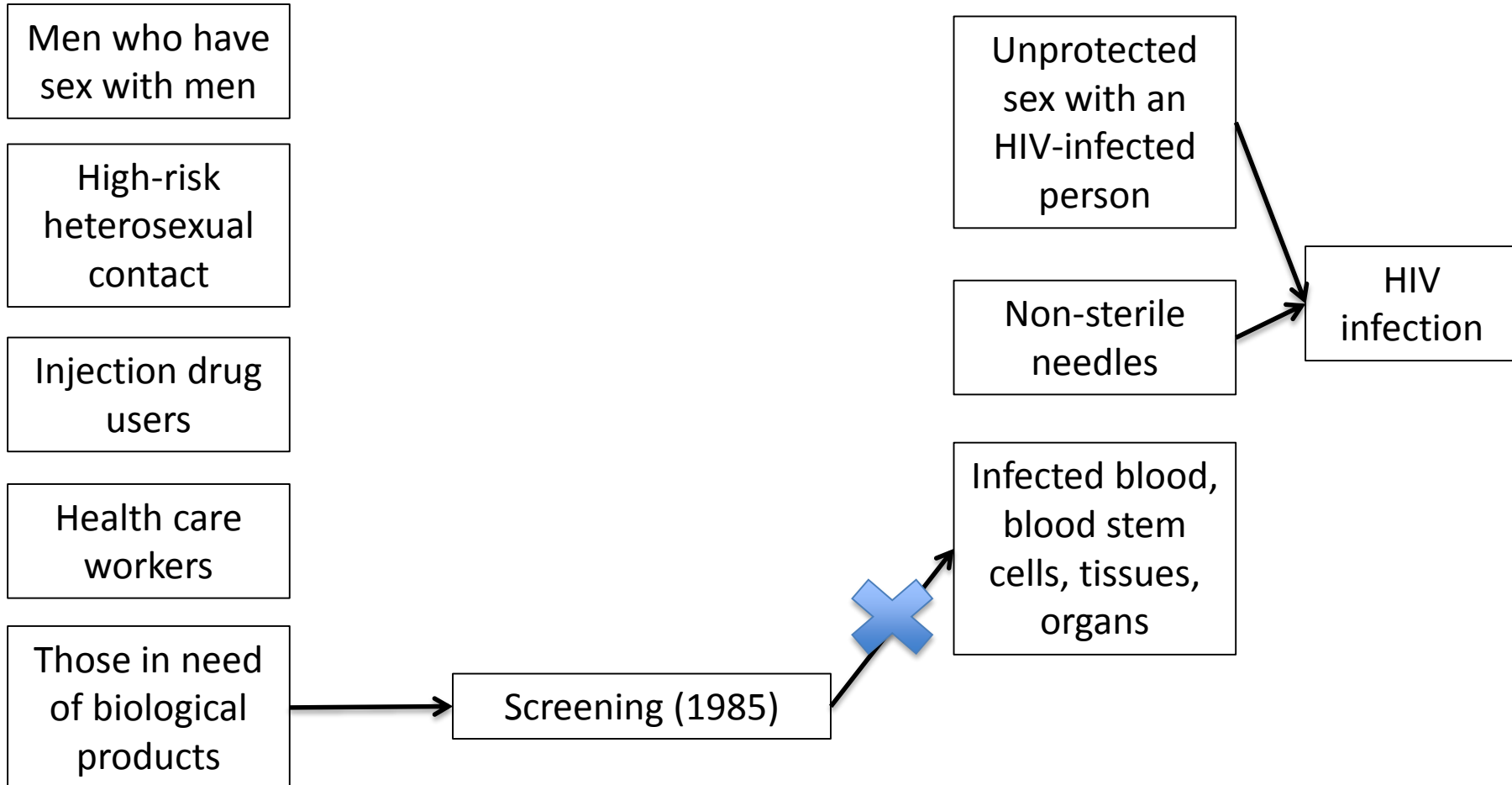
Unprotected
sex with an
HIV-infected
person

Non-sterile
needles

Infected blood,
blood stem
cells, tissues,
organs

Outcome

HIV
infection



Blood supply screening

- Blood supply screening began as soon as an HIV test was available (1985)
- “Your risk of getting HIV from a blood transfusion is lower than your risk of getting killed by lightning. Only about 1 in 2 million donations might carry HIV and transmit HIV if given to a patient.”
- Last known transmission from a biological product: 2008

Barriers to prevention

Individual characteristics

Men who have
sex with men

High-risk
heterosexual
contact

Injection drug
users

Health care
workers

Those in need
of biological
products

Universal
precautions (1987)

Screening (1985)

Immediate causes

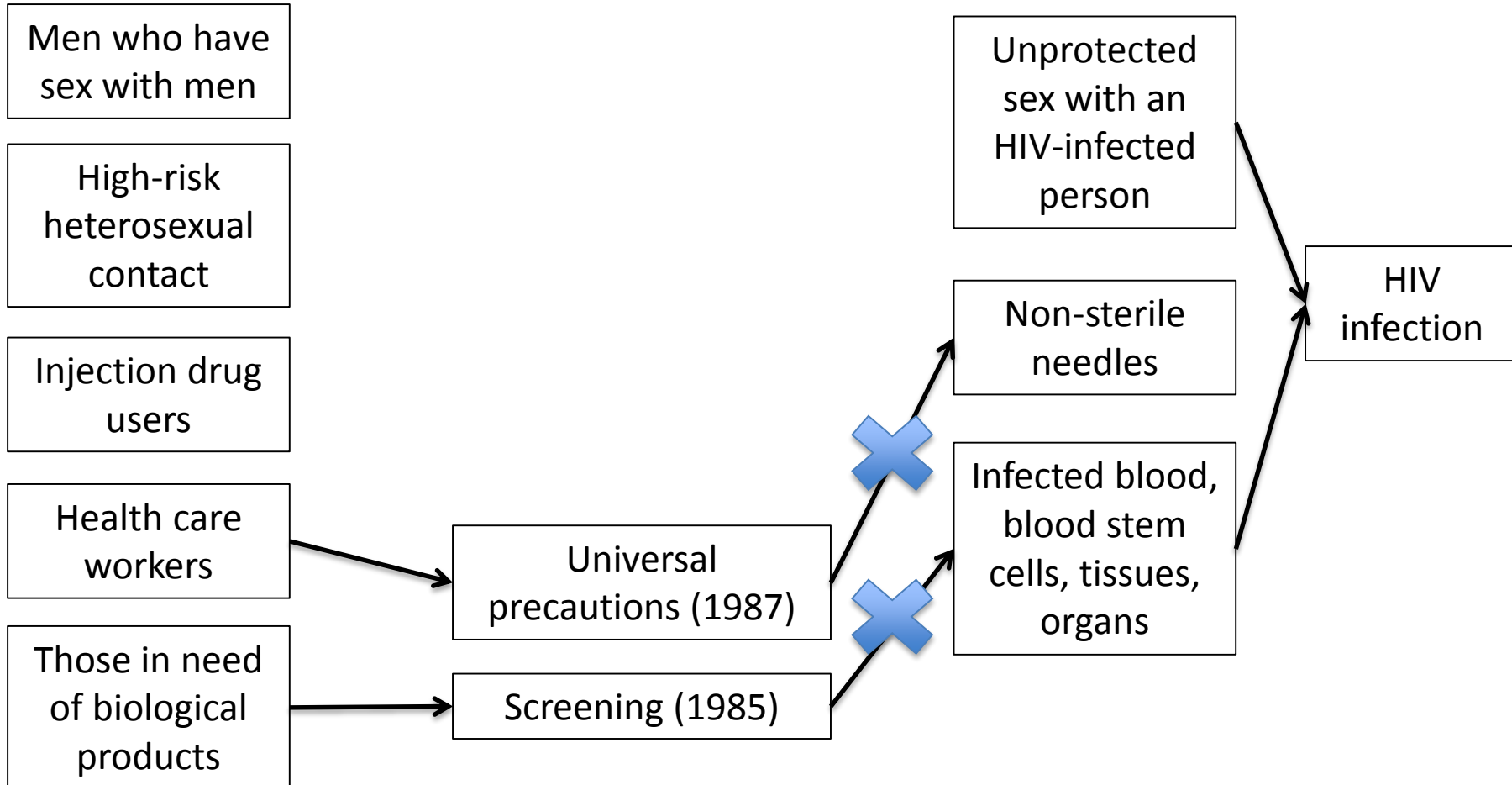
Unprotected
sex with an
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person

Non-sterile
needles

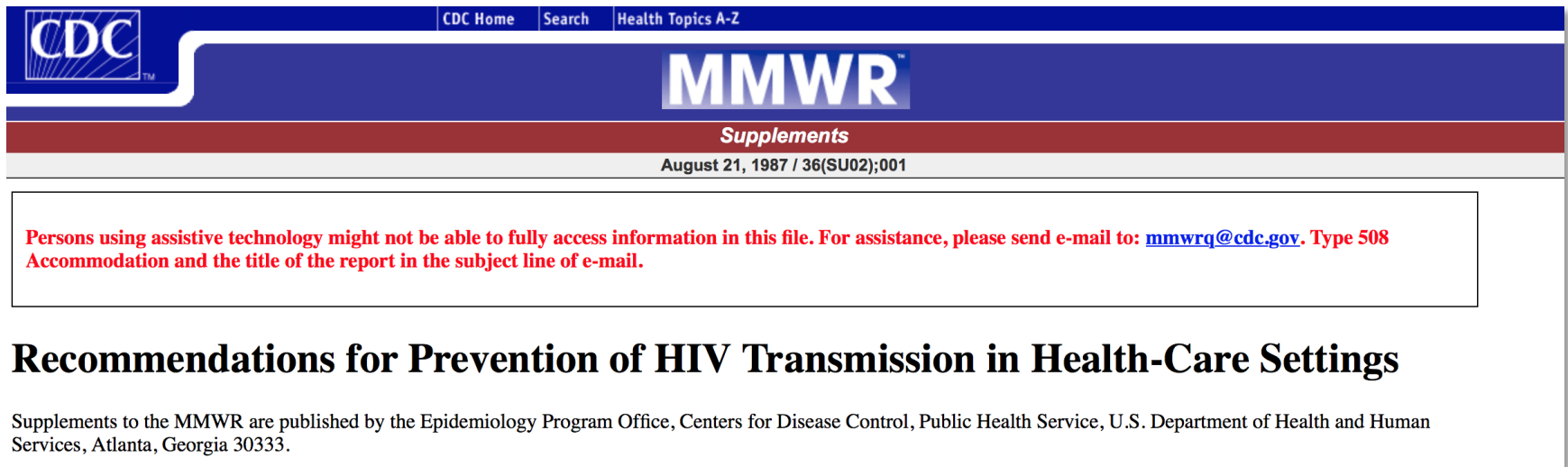
Infected blood,
blood stem
cells, tissues,
organs

Outcome

HIV
infection



Universal Precautions, 1987



The screenshot shows the top of a CDC MMWR Supplements webpage. At the top left is the CDC logo. To its right are links for 'CDC Home', 'Search', and 'Health Topics A-Z'. The main header features the 'MMWR' logo in large white letters on a blue background, with 'Supplements' written in red below it. A date line indicates 'August 21, 1987 / 36(SU02);001'. A red-bordered box contains a notice about assistive technology. Below this is the title 'Recommendations for Prevention of HIV Transmission in Health-Care Settings' and a paragraph about the publication's origin.

CDC Home Search Health Topics A-Z

MMWR
Supplements

August 21, 1987 / 36(SU02);001

Persons using assistive technology might not be able to fully access information in this file. For assistance, please send e-mail to: mmwrq@cdc.gov. Type 508 Accommodation and the title of the report in the subject line of e-mail.

Recommendations for Prevention of HIV Transmission in Health-Care Settings

Supplements to the MMWR are published by the Epidemiology Program Office, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, Georgia 30333.

- Barriers to protect skin and mucosal membranes from bodily fluids
- Prevention of acquiring a number of infectious agents, not only HIV

Barriers to prevention

Individual characteristics

Men who have
sex with men

High-risk
heterosexual
contact

Injection drug
users

Health care
workers

Those in need
of biological
products

Sterile syringe
programs (SSPs)

Universal
precautions (1987)

Screening (1985)

Immediate causes

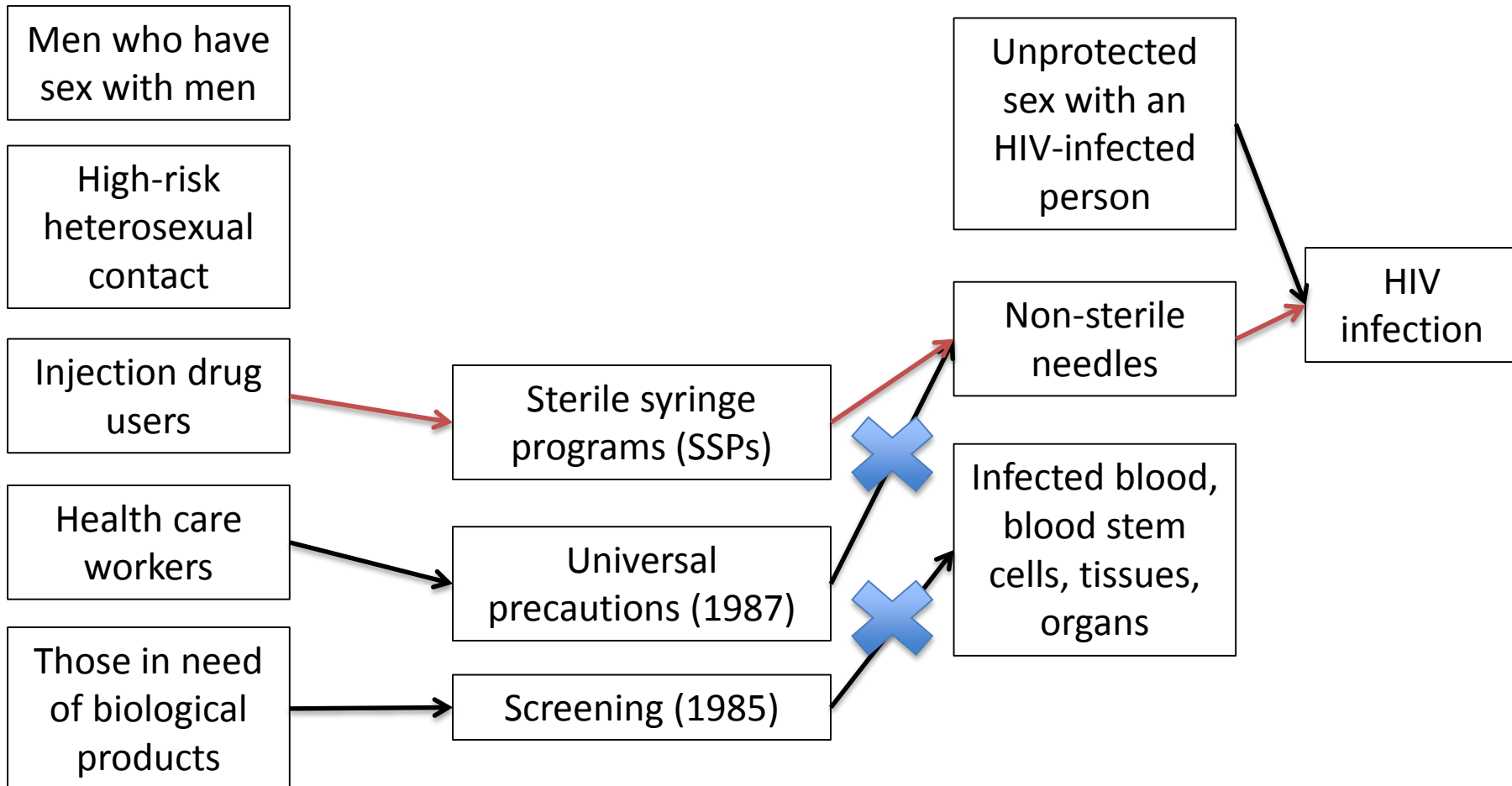
Unprotected
sex with an
HIV-infected
person

Non-sterile
needles

Infected blood,
blood stem
cells, tissues,
organs

Outcome

HIV
infection



Sterile syringe programs

- Consolidated Appropriations Act of 2016
 - federal funds cannot be used for needles, syringes, or other injection equipment
 - federal funds can be used for personnel, syringe disposal, naloxone, HIV & HCV testing kits, linkage to care resources, condoms, educational materials
- Most current data show only 1 in 4 PWIDs got all of their syringes from sterile sources in 2015

<https://www.cdc.gov/vitalsigns/hiv-drug-use>,

National Survey on Drug Use and Health, 2002-2013

Federal funds for needles

- Indiana, March 26, 2015:
Gov. Mike Pence declares a public health emergency due to an HIV outbreak among PWID
- Indiana, April 6, 2016: Federal funds were used for needle exchange
- "Emergency needle exchange was necessary, feasible, and successful."

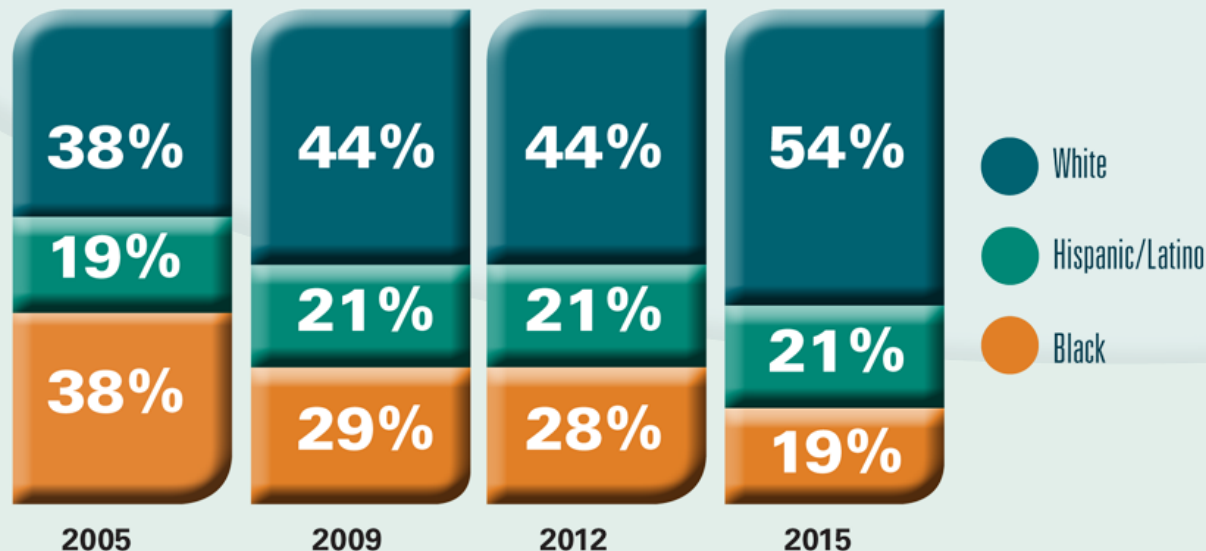


Michael Conroy/AP

Changing demographics of PWID

Changes in who is starting to inject drugs

Percent of new PWID by race suggests fewer blacks, and more whites, are starting to inject drugs



SOURCE: CDC's National HIV Behavioral Surveillance data, 2005-2015

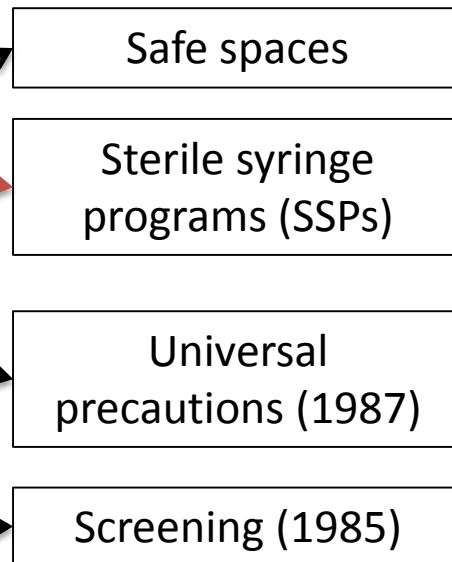
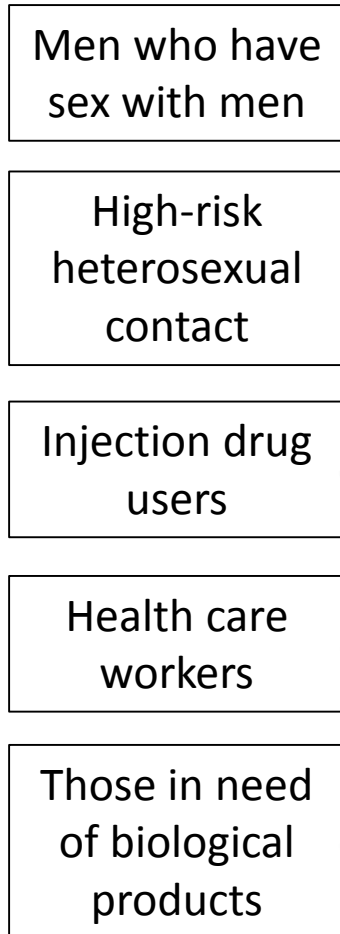
60%

Heroin use has increased more than **60%** (114% in whites) in recent years. The heroin and prescription opioid epidemics could lead to new HIV outbreaks.

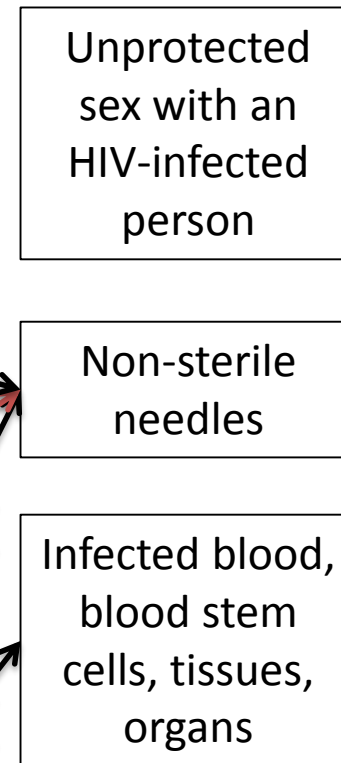
SOURCE: National Survey on Drug Use and Health, 2002-2013

Barriers to prevention

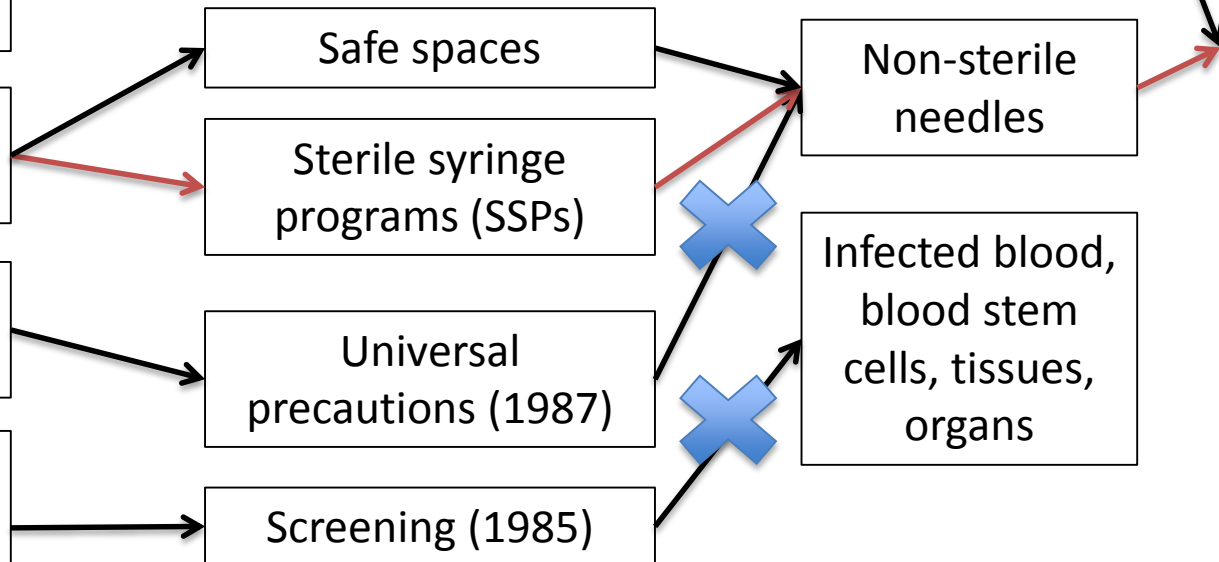
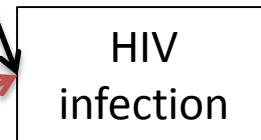
Individual characteristics



Immediate causes



Outcome



Safe Spaces

[Crime](#) | [Health](#) | [Local News](#) | [Local Politics](#) | [Puget Sound](#)

Open 'safe places' in Seattle, King County for heroin use, task force says

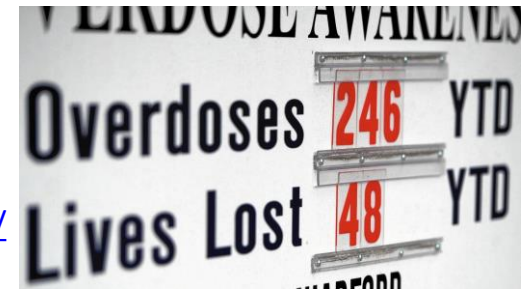
Originally published September 15, 2016 at 10:10 am | Updated September 15, 2016 at 5:52 pm

The Seattle Times

- Goal is to prevent
 - prevent injection in public restrooms, alleys, homeless encampments
 - prevent overdose death
 - offer medical, prevention, treatment, services

Safe spaces to monitor fentanyl

- Vancouver, July 7-August 3, Insite safe space:
 - 86% of 173 test were positive for fentanyl
<http://www.theglobeandmail.com/news/politics/health-canada-plans-to-restrict-chemicals-used-to-make-fentanyl/article31637715/>
- Harford County, MD, over Thanksgiving (Wednesday-Sunday), 2016:
 - 5 overdose deaths in 5 days <http://www.baltimoresun.com/news/maryland/harford/aegis/ph-ag-heroin-deaths-rising-1130-20161129-story.html>
- In 2015, the CDC estimates 13,150 people died from heroin overdose, which is more than firearm homicides, melanoma, or HIV
<http://abcnews.go.com/Health/heroin-overdoses-killed-people-us-hiv-melanoma-firearms/story?id=44087454>



Matt Button, Aegis / Baltimore Sun

Barriers to prevention

Individual characteristics

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sex with men

High-risk
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Injection drug
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Health care
workers

Those in need
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Safe spaces

Sterile syringe
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Immediate causes

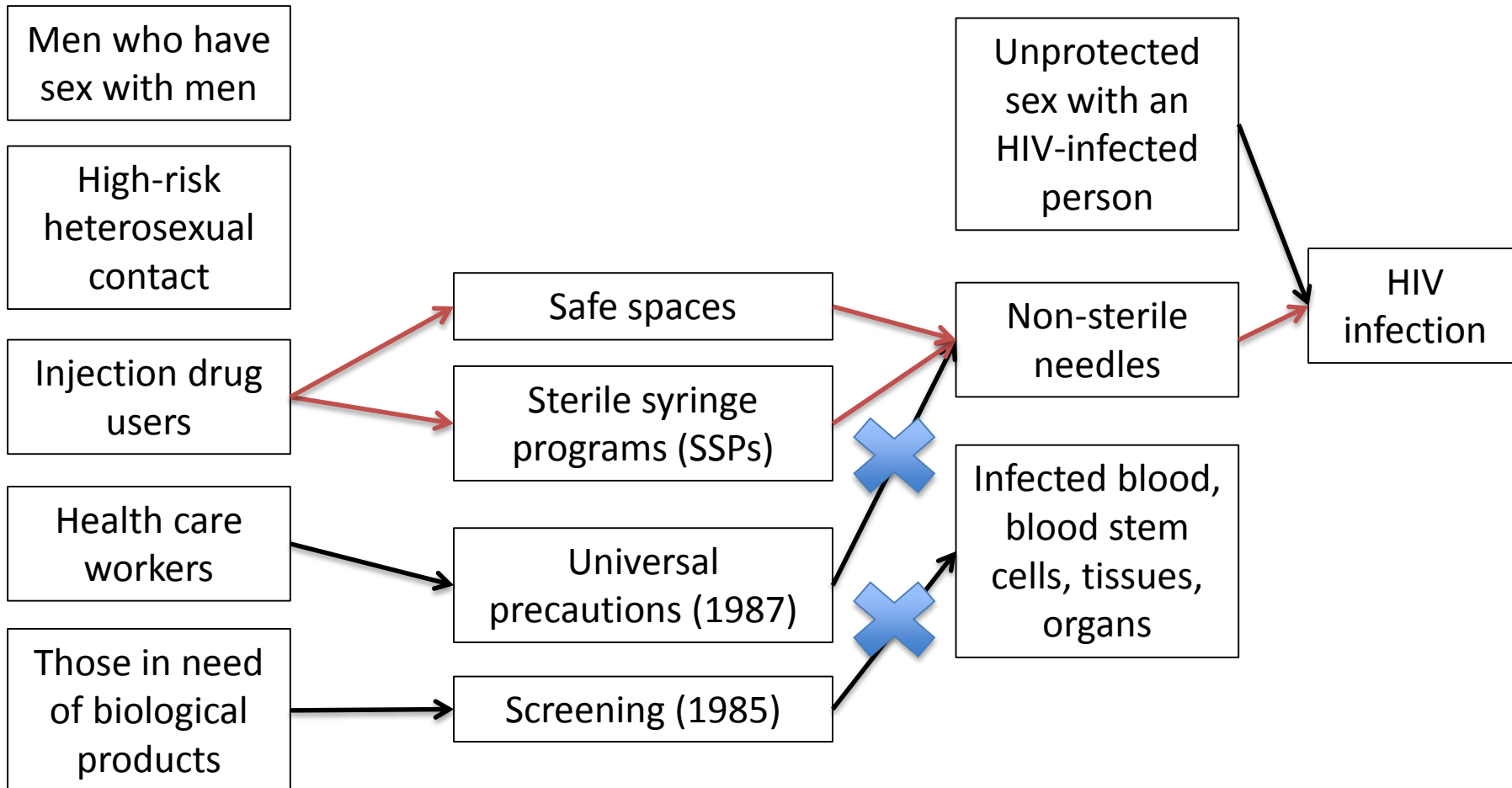
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HIV
infection



Barriers to prevention

Individual characteristics

Men who have sex with men

High-risk heterosexual contact

Injection drug users

Health care workers

Those in need of biological products

Partner's/associate's access to STI and HIV treatment (viral suppression)

PrEP

Safe spaces

Sterile syringe programs (SSPs)

Universal precautions (1987)

Screening (1985)

Immediate causes

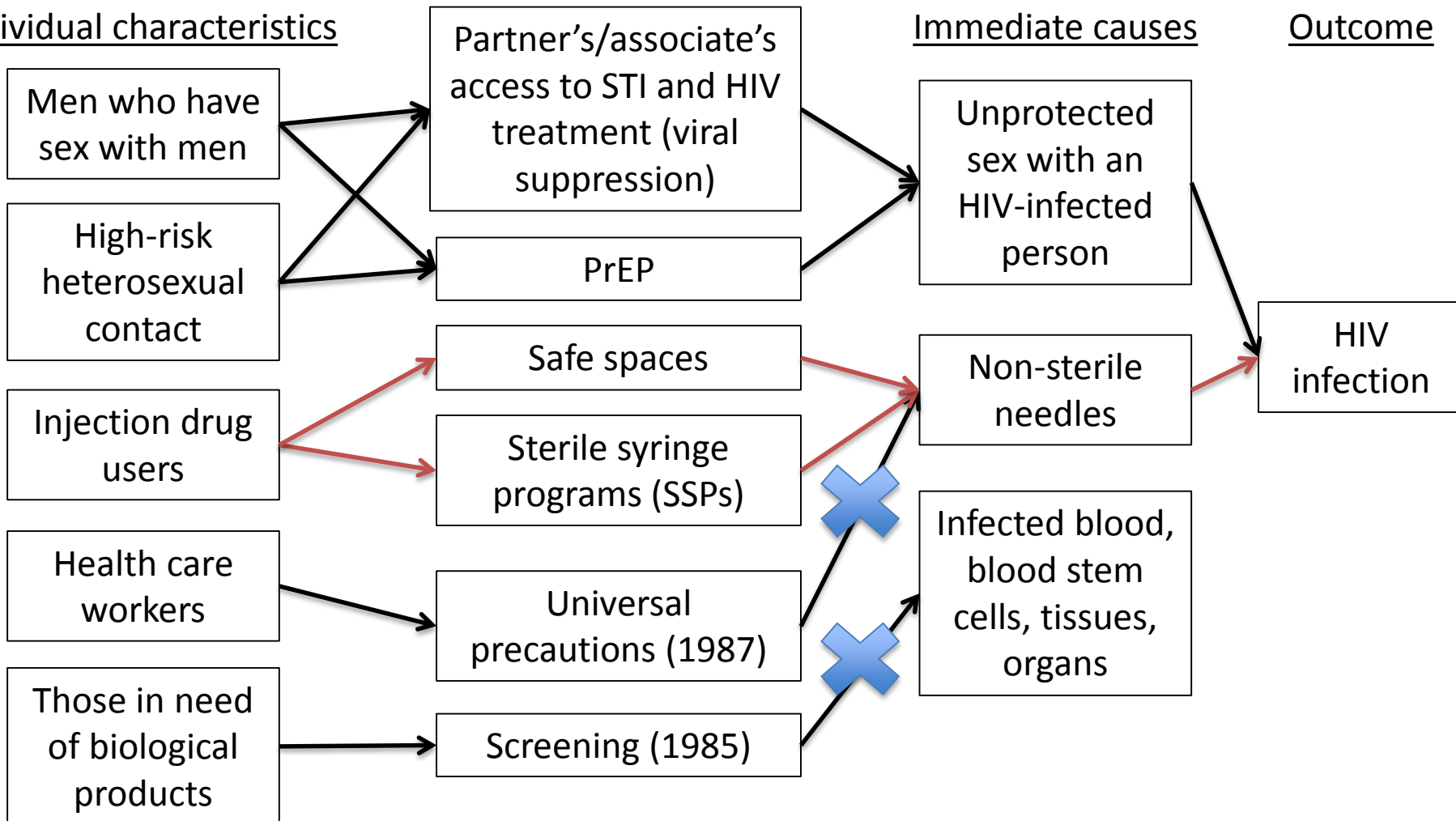
Unprotected sex with an HIV-infected person

Non-sterile needles

Infected blood, blood stem cells, tissues, organs

Outcome

HIV infection



Treatment as prevention

- PrEP and ART work
 - Reduction in HIV acquisition risk for those using PrEP
 - Clear reduction in HIV transmission risk for those with suppressed HIV RNA
- Biggest barriers
 - Knowing your status
 - Access to care & costs
 - Stigma

Status: HIV Guidelines for Testing

- Routine testing for all patients 13-64yo
 - unless prevalence in their patients has been documented to be $<0.1\%$
- Annual testing for
 - PWID and sex partners of PWID
 - persons who exchange sex for money or drugs
 - sex partners of an HIV-infected person
 - heterosexual persons who have had more than one sex partners since their most recent HIV test
 - MSM

Status: Gender and sexual practices

- Sex is recorded in most medical records
- Discussions of sexual practices between physicians are needed
 - 9.3% of sexually active teens report having a same-sex partner
 - Of these, 38.9% identify as heterosexual
 - 72.8% of MSM identified as heterosexual

Pathela, et al. Pediatrics, 2010.

Pathela, et al. Annals of Internal Medicine, 2006.

Status: Gender and sexual practices



- Changes to medical school curriculum
- Modifying the electronic medical record to force these questions
 - smoking

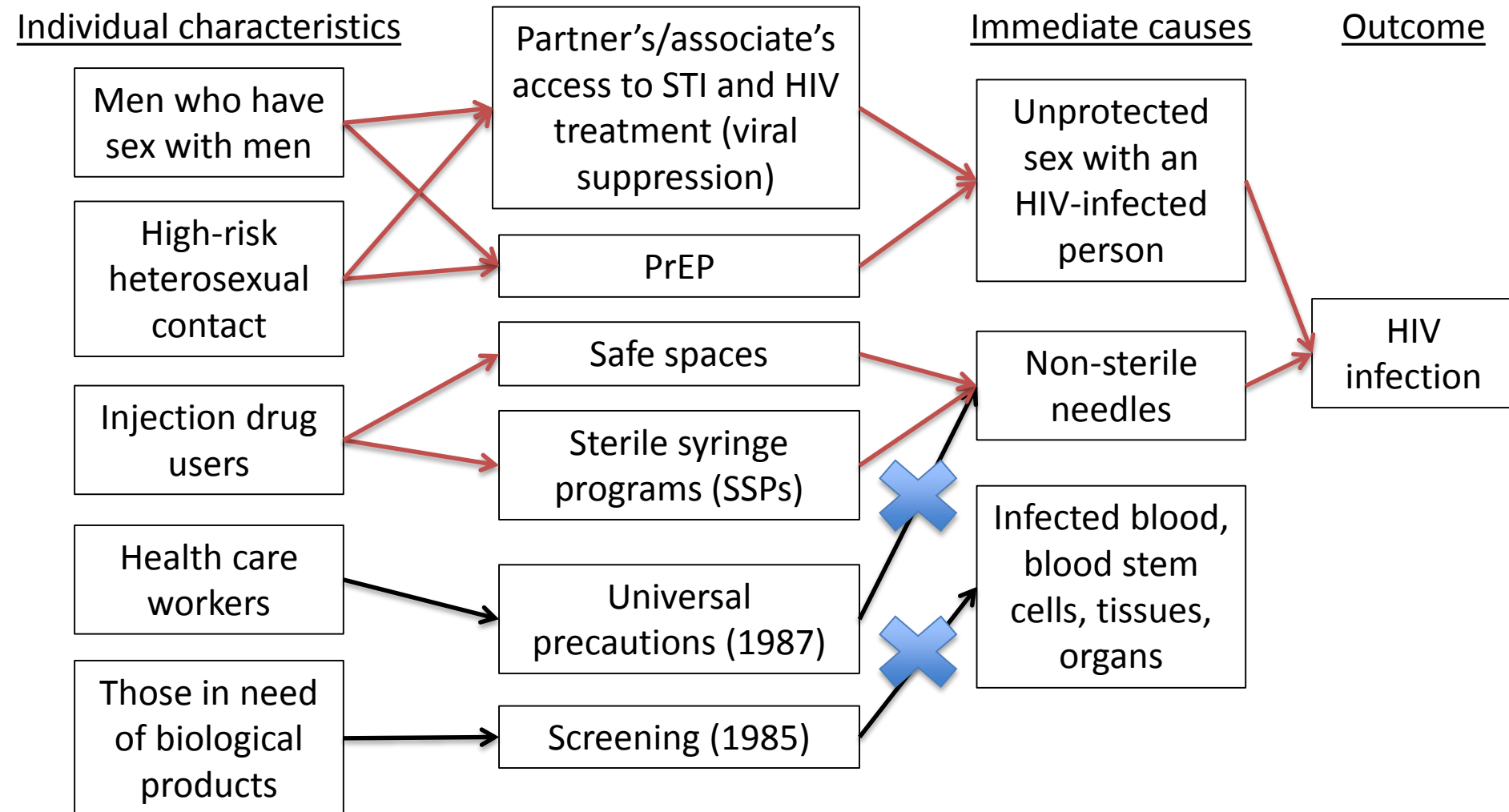
<http://www.epic.com/software>

Access to care: The ACA

- PrEP and ART require access to care
 - 20 million people were covered with the Affordable Care Act (ACA)
- Possible DHHS Secretary Rep. Tom Price (GA) ACA replacement plan:
 - Fixed tax credits
 - Expand healthcare savings accounts
 - People can't be denied coverage based on existing condition, if that person had health insurance in the prior 18 months
 - Limit the tax deduction company's employee health insurance expenses (discourages generous plans)
 - High-risk pools

<http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf>

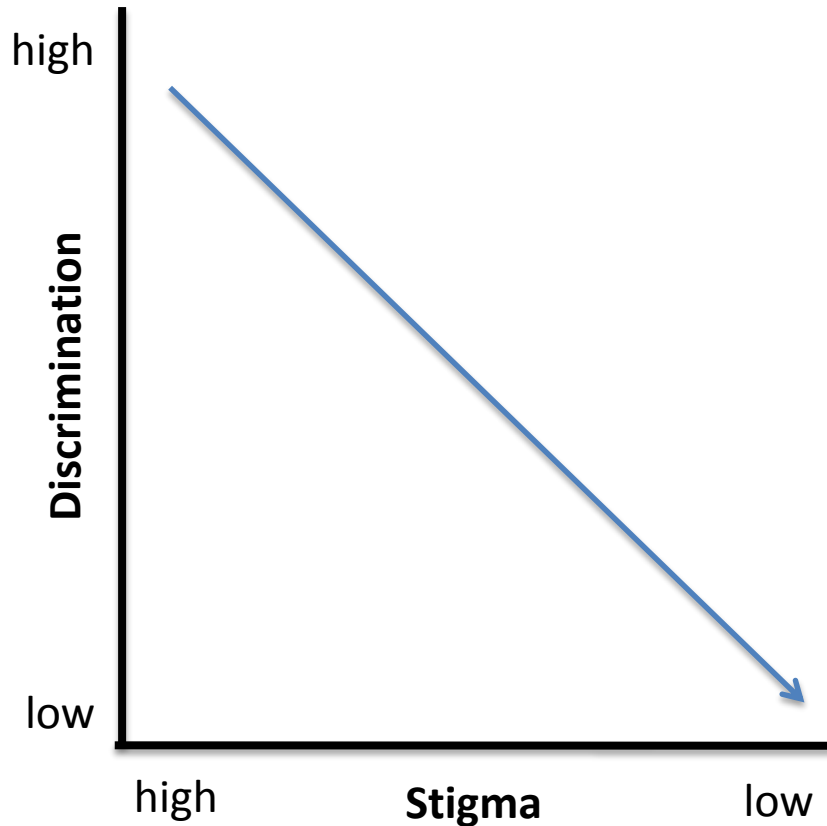
Barriers to prevention



Overview

- Existing structural bridges and barriers
- New initiatives

Discrimination & stigma at the structural level



- Legislated and legal discrimination
- Community-based stigma

Legal or Legislated Discrimination

- States attempting to use “Religious Freedom Restoration Acts” bills to deny services to LGBT people
- Bathroom bills
- Funding student organizations at public universities, even if they discriminates against LGBT people based on religious beliefs
- Health professionals can deny services to LGBT people by citing religious objections
- All politics are local: CO, HI, IA, MI, MS, NC, OK, IL, KS, KY, MN, MO, SC, TN, AB, NE, CA,

Community-based stigma

- Role of religious organizations in HIV prevention
- “The Black Church and HIV: The Social Justice Imperative,” NAACP 2012

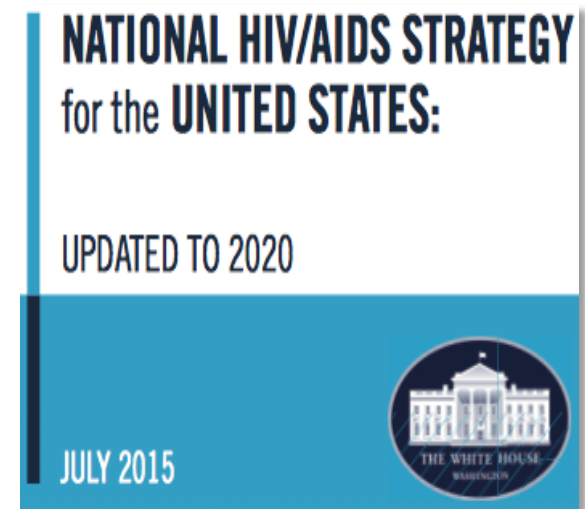


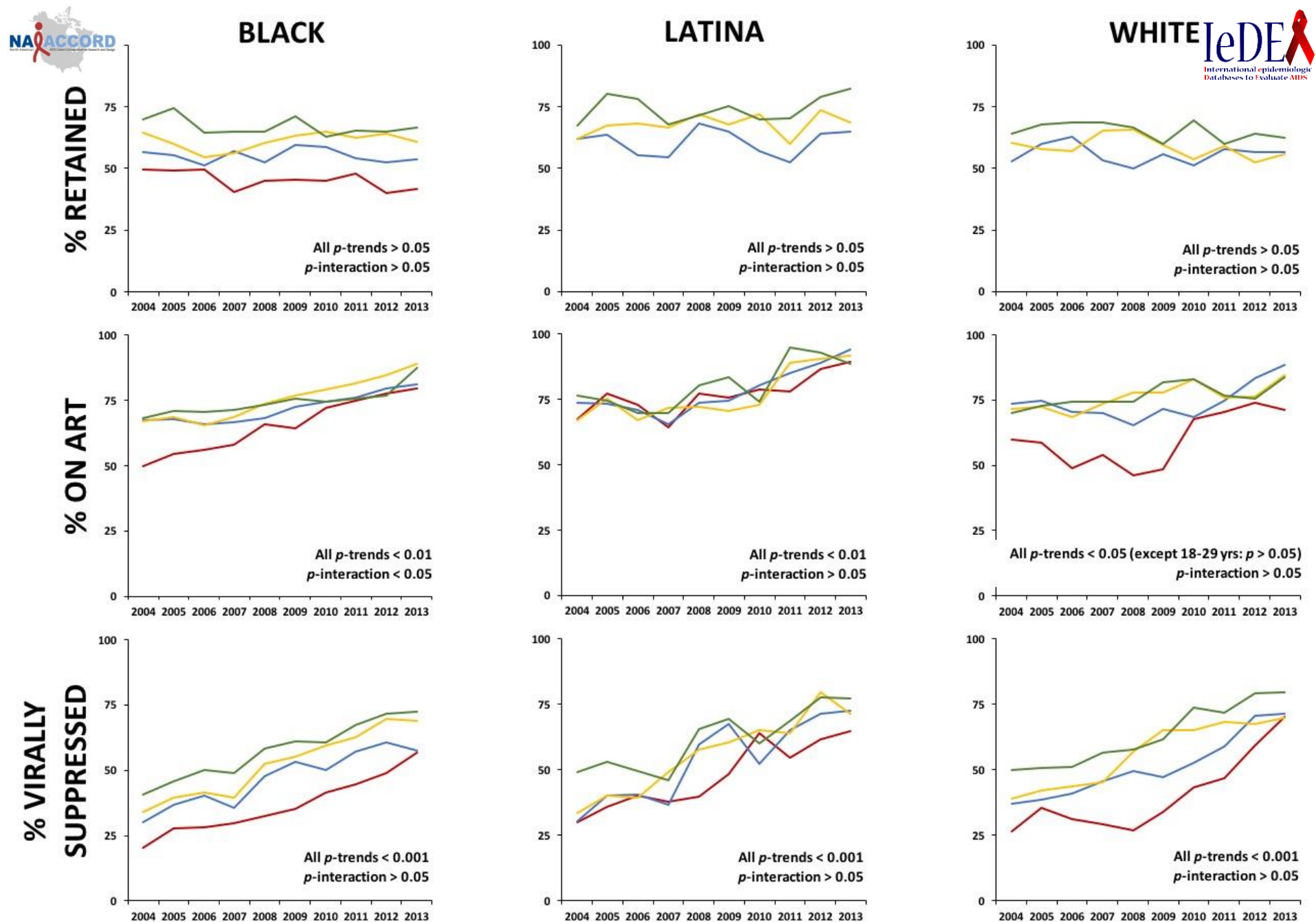
Shine A Light

Terrinieka Powell draws on higher powers to confront Baltimore's HIV/AIDS epidemic.
Hopkins Bloomberg Public Health Magazine, Fall 2016

From indicators in **key populations...**

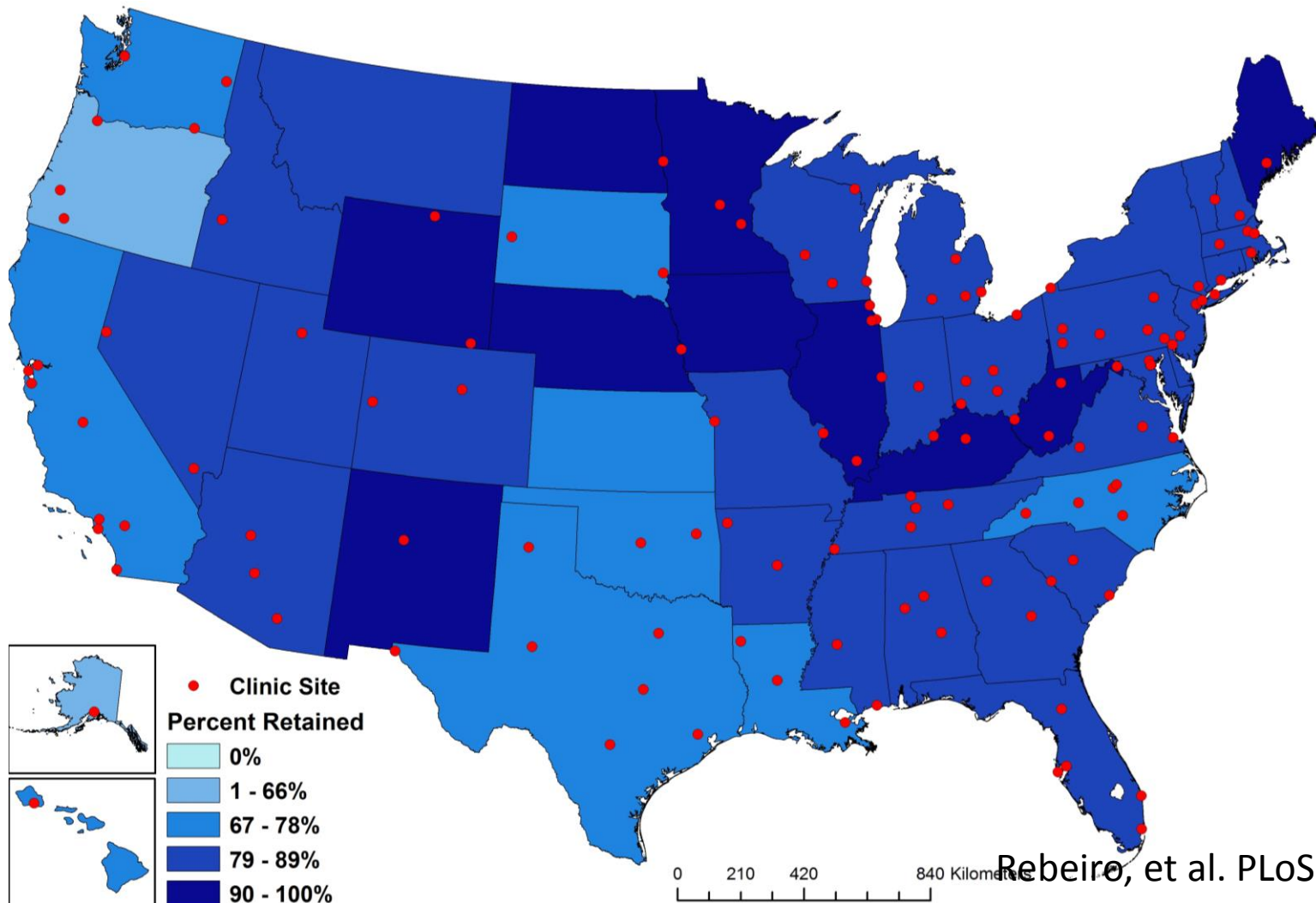
- NHAS Update to 2020:
 1. Reduce new infections, focus on key populations:
 - MSM
 - Black
 - Latino
 - PWID
 - Youth <25yo
 - People in the south
 - Transgender women
 2. Increase access to care
 3. Reduce HIV-related disparities and health equities





Age groups: 1) ≥ 18 to < 30 years, 2) ≥ 30 to < 40 years, 3) ≥ 40 to < 50 years, 4) ≥ 50 years

...to indicators in states,
stratified by policy



Rebeiro, et al. PLoS ONE, 2016.

Conclusions

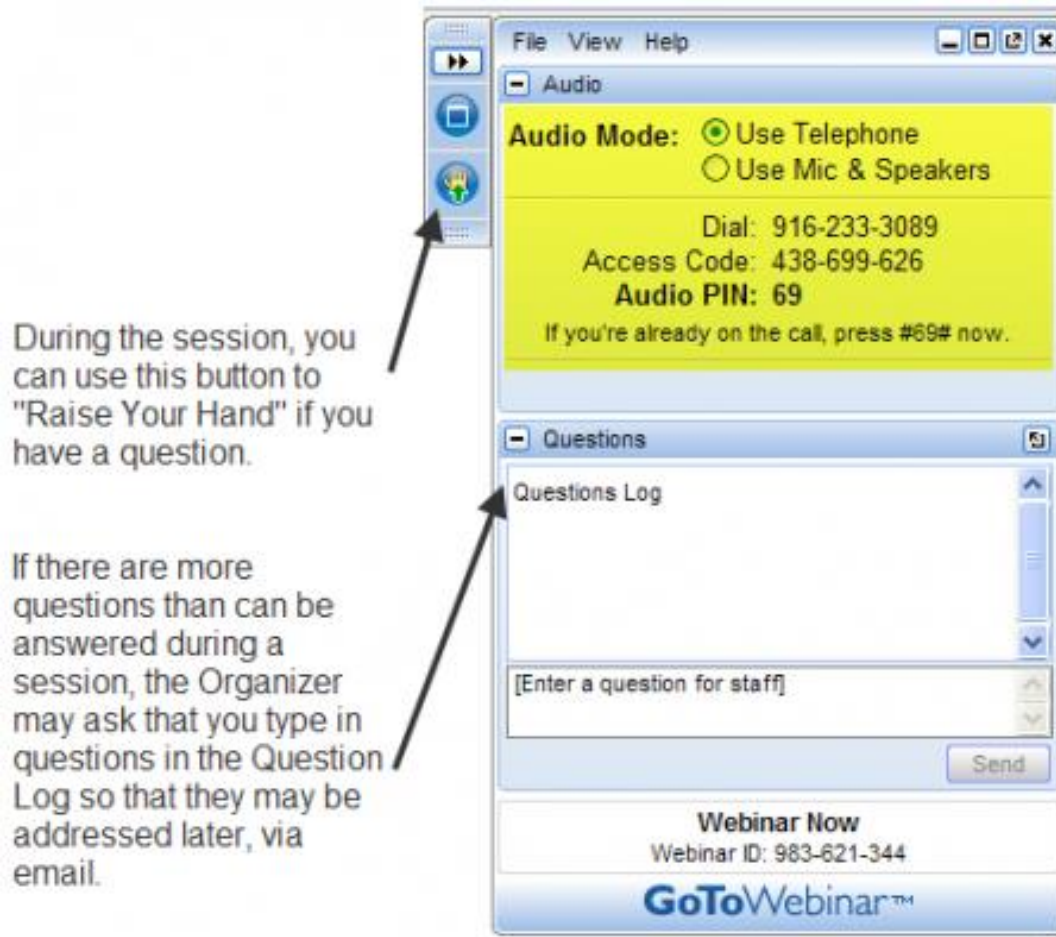
- Structural-level interventions to connect those at risk to biomedical prevention interventions may have a **bigger** impact than individual-level interventions
- Next steps
 - Focus on existing HIV indicators stratified by geographic regions with (and without) structural barriers
 - New indicators

Acknowledgements

- NA-ACCORD (www.naaccord.org)
 - Peter Rebeiro
 - Stephen Gange
 - Richard Moore
 - Kelly Gebo
- leDEA (www.iedea.org)
- White House Office of National AIDS Policy
- Jeremiah Johnson – Treatment Action Group

Questions?

- You may also email your questions to mboykin@aidschicago.org



TAG

Treatment Action Group

HIV•PJA

HIV PREVENTION JUSTICE ALLIANCE



Thank you!

HIV Prevention Justice Alliance:

www.preventionjustice.org

- Stay up to date on advocacy opportunities with our email blasts!
- Follow HIV PJA on Twitter @HIVPrevJustice

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HIV PREVENTION JUSTICE ALLIANCE

Download slides & materials at: www.preventionjustice.org

